MEDIGAP INSURANCE: THE NEW CATASTROPHE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

NOVEMBER 2, 1989

Comm. Pub. No. 101-747

Printed for the use of the Select Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

26-892 ⇆ WASHINGTON : 1990

For sale by the Superintendent of Documents, Congressional Sales Office
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MEDIGAP INSURANCE: THE NEW CATASTROPHE

THURSDAY, NOVEMBER 2, 1989

U.S. House of Representatives,
Select Committee on Aging,
Subcommittee on Health and Long-Term Care,
Washington, DC

The subcommittee met, pursuant to call, at 9:35 a.m., in Room 345, Cannon House Office Building, Hon. Edward R. Roybal (chairman of the subcommittee) presiding.

Members present: Representatives Roybal, Oakar, Frank, Skelton, Borski, Wise, Regula, Rinaldo, Smith, Bentley, Fawell, Bilbray and Schuette.

Staff present: Kathleen Gardner Cravedi, Staff Director; Melanie Modlin, Assistant Staff Director; Peter Reinecke, Research Director; Pat Kim, Intern; and Mark Benedict, Minority Staff Director.

OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

Mr. Roybal. The committee will come to order.

Ladies and gentlemen, the purpose of today's hearing is to examine the reasonableness of reported cost increases for private insurance plans. These are plans that senior citizens buy throughout the country. It is estimated that 70 percent of all Medicare beneficiaries, some 22 million people, have insurance to supplement Medicare, with the average policy costing $800.

Our Nation's senior citizens will spend approximately $17 billion on Medigap insurance in the year 1989. That's a tremendous industry, ladies and gentlemen—$17 billion.

During debate and hearing proceedings during the passage of the Medicare Catastrophic Act, the insurance companies told the committee that premiums should go down. Unfortunately, that doesn't seem to have happened. I base that on the fact that this week we surveyed all State Departments of Insurance across the United States, and literally every State reported that they experienced an increase in their Medigap insurance plans, ranging from a high of 133 percent in the State of Arizona to a 9 percent increase in South Carolina.

Now, this is a tremendous difference between an increase of 133 percent and then only 9 percent, all in the same country, all for policies providing care for people of approximately the same age.

Most States we surveyed also reported that companies will file for further increases in their Medigap plans in 1990 regardless of whether the Medicare Catastrophic Act is repealed. And it was reported that in Massachusetts, the largest Medigap plan has requested a 33 percent increase for 1990, that is if the Catastrophic

Act were not to be repealed. If it is repealed, they will request a 74 percent hike.

Now, is this nothing more than profiteering on the part of the insurance industry?

These are questions that the committee asked and I think that the general public is asking. These are questions that I hope we will get some answers to today. It is our plan to continue looking into the situation to find out exactly where the truth lies.

Now, more shocking to the subcommittee was our survey finding that two-thirds of the States said that they did not have a formal mechanism to approve increases in policies sold to groups or to individuals. In other words, the companies were not require to get approval from the State or anyplace else—they go right ahead and increase their fees. No one seems to be looking over their shoulder, either approving or disapproving.

About one-third don't require approval of increases in individual plans. There are group Medigap plans and then there are individual plans, but here one-third of the States reported that they don't even get an opportunity to look at the individually sold plans. The increases just go into effect without any scrutiny by the insurance department.

These are some of the things that were uncovered as we conducted the survey, and the purpose of the hearing today is to get some answers. And if are not able to get all the answers we intend to continue hearings not only here in Washington but throughout the country.

[The prepared statement of Mr. Roybal follows:]

PREPARED STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

LADIES AND GENTLEMEN. MEMBERS OF THE SUBCOMMITTEE. TODAY'S HEARING IS OF SERIOUS CONCERN TO OUR NATION'S ELDERLY -- THAT IS, THE CONTROVERSIAL INCREASES IN PRIVATE INSURANCE POLICIES PURCHASED BY THE ELDERLY TO SUPPLEMENT MEDICARE. OF GREATER CONTROVERSY WILL BE OUR FINDING THAT THE MAJORITY OF STATES ARE NOT REQUIRED TO APPROVE OR SCRUTINIZE THE NEED FOR SUCH INCREASES.

IT IS ESTIMATED THAT 70 PERCENT OF ALL MEDICARE BENEFICIARIES, SOME 23 MILLION PEOPLE, HAVE INSURANCE TO SUPPLEMENT MEDICARE. SUCH INSURANCE IS CALLED "MEDIGAP." WITH THE AVERAGE POLICY COSTING ABOUT $800, OUR NATION'S SENIOR CITIZENS WILL SPEND APPROXIMATELY $17 BILLION ON MEDIGAP INSURANCE IN 1989.

LAST YEAR, THE CONGRESS ENACTED THE MEDICARE CATASTROPHIC ACT WHICH GREATLY EXPANDED THE COVERAGE PROVIDED BY THE MEDICARE PROGRAM WHILE AT THE SAME TIME REDUCING THE AMOUNT OF LIABILITY TO BE BORNE BY THE INSURANCE INDUSTRY. WE THOUGHT THAT THE COST OF MEDIGAP INSURANCE WOULD GO DOWN. IT MAKES SENSE. IF THE FEDERAL GOVERNMENT IS PAYING MORE OF THE SENIOR CITIZEN'S HEALTH CARE COSTS, PRIVATE INSURANCE WILL BE REQUIRED TO PAY LESS.

DURING DEBATES AND HEARINGS PRECEEDING THE PASSAGE OF THE MEDICARE CATASTROPHIC ACT, THE INSURANCE INDUSTRY ITSELF SAID THAT INSURANCE PREMIUMS SHOULD GO DOWN. AT A JUNE, 1987 HEARING, A REPRESENTATIVE OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, WHOM WE WILL HEAR FROM TODAY, SAID: "THE PREMIUM HAS TO RELATE TO THE BENEFITS THAT ARE BEING PROVIDED AND THESE BENEFITS ARE NOW GOING TO BE 'PICKED UP BY THE GOVERNMENT.' I WILL GUARANTEE YOU THAT COSTS WILL GO DOWN."

UNFORTUNATELY, THAT DIDN'T HAPPEN. IN JANUARY, 1989 WHEN THE PART A HOSPITAL PROVISIONS OF THE CATASTROPHIC ACT WENT INTO EFFECT, LIMITING THE HOSPITAL DEDUCTIBLE TO ONE ANNUAL PAYMENT OF $564 AND ELIMINATING THE DAILY COPAYMENTS FOR A HOSPITAL STAY OF LONGER THAN 60 DAYS, ONE WOULD HAVE EXPECTED MOST MEDIGAP POLICY COSTS TO DECREASE. THIS WEEK I SURVEYED ALL STATE DEPARTMENTS OF INSURANCE ACROSS THE UNITED STATES. LITERALLY EVERY STATE REPORTED THAT THEY EXPERIENCED AN INCREASE IN SOME OF THEIR MEDIGAP INSURANCE PLANS, RANGING FROM A HIGH OF A 133% INCREASE IN AN ARIZONA PLAN TO A LOW OF A 9% INCREASE IN A SOUTH CAROLINA INSURANCE PLAN. OVER HALF OF THE STATES REPORTED THAT SOME OF THEIR PLANS INCREASED BY AT LEAST 25%. NEW YORK HAD PLANS WHICH INCREASED 62%. CALIFORNIA REPORTED ONE PLAN INCREASING BY 75%. HERE IN THE DISTRICT OF COLUMBIA, INCREASES OF UP TO 55% WERE INITIATED IN 1989.

MOST STATES WE SURVEYED ALSO REPORTED THAT COMPANIES WILL FILE FOR FURTHER INCREASES IN THEIR MEDIGAP PLANS IN 1990 REGARDLESS OF WHETHER OR NOT THE MEDICARE CATASTROPHIC ACT IS REPEALED. THE DEBATE THAT REMAINS IS ONLY ON THE AMOUNT OF INCREASE. FOR EXAMPLE, WE WILL HEAR TESTIMONY TODAY FROM A MASSACHUSETTS WITNESS WHO WILL DETAIL HOW THAT STATE'S PRIMARY MEDIGAP PLAN INCREASED 10% IN 1989, AND HAS REQUESTED A 33% INCREASE FOR 1990 IF THE CATASTROPHIC ACT IS NOT ENTIRELY REPEALED. IF IT IS REPEALED, THEY WILL REQUEST A 74% INCREASE. OTHER INSURANCE COMPANIES HAVE REPORTED SIMILAR INTENTIONS.

ARE THESE INCREASES JUSTIFIED. ABSOLUTELY NOT. IS THIS NOTHING MORE THAN PROFITTERING ON THE PART OF THE INSURANCE INDUSTRY? WE WILL HEAR FROM WITNESSES TODAY WHO WILL REPORT THAT MEDIGAP PREMIUM INCREASES SHOULD MIRROR ANNUAL AVERAGE INCREASES IN THE MEDICARE PROGRAM. THE MEDICARE PROGRAM EXPERIENCED TOTAL COST INCREASES OF APPROXIMATELY 10% A YEAR FROM 1987 TO 1989 -- THIS INCLUDES INFLATION, NEW BENEFICIARIES, AND INCREASED UTILIZATION. EXPERTS TELL US THAT PRIVATE INSURANCE SUPPLEMENTING MEDICARE SHOULD NOT BE EXPECTED TO INCREASE MORE THAN THE MEDICARE EXPERIENCE. OBVIOUSLY, THE STATES ARE TELLING US THIS IS NOT THE CASE. IN FACT, AN OFFICIAL FROM THE STATE OF DELAWARE SAID THAT THEY SCRUTIZE VERY CLOSELY ANY REQUEST FOR AN INCREASE IN EXCESS OF 15%.

MORE SHOCKING TO THE SUBCOMMITTEE WAS OUR SURVEY FINDING THAT THE MAJORITY OF THE STATES DO NOT REQUIRE THAT MEDIGAP PREMIUM INCREASES BE FORMALLY APPROVED BEFORE GOING INTO EFFECT. TWO-THIRDS OF THE STATES SAID THEY DID NOT APPROVE INCREASES IN POLICIES SOLD TO GROUPS OF INDIVIDUALS. ABOUT ONE-THIRD DON'T REQUIRE APPROVAL OF INCREASES IN INDIVIDUAL PLANS. THE MAJORITY OF THE STATES SURVEYED ALSO INDICATED THAT THEY DO NOT EVEN REQUIRE THAT INSURANCE COMPANIES FILE THEIR PLANNED INCREASES. THEY JUST GO INTO EFFECT WITHOUT ANY SCRUTINY BY THE INSURANCE DEPARTMENT. THIS MAKES ABSOLUTELY NO SENSE. EVEN PUBLIC UTILITIES MUST SHOW JUST CAUSE FOR RATE HIKFS. WHY SHOULDN'T INSURANCE COMPANIES BE HELD ACCOUNTABLE FOR THEIR RATE INCREASES?

CONSIDER THE PLIGHT OF OUR NATION'S SENIOR CITIZENS. WHAT ARE THEY TO DO WHEN THESE INCREASES ARE IMPOSED. THEY ARE TRAPPED. THEY CAN EITHER DROP THEIR INSURANCE ALTOGETHER -- AND MANY WILL HAVE TO -- OR, THEY CAN SWITCH THEIR POLICY TO A LESS COSTLY ONE AND BE PENALIZED FOR DOING SO. IF YOU SWITCH POLICIES, IN MOST INSTANCES YOU ARE REQUIRED TO WAIT A PERIOD OF TIME BEFORE PREEXISTING ILLNESSES ARE COVERED.

IF WE IN THE UNITED STATES ARE TO CONTINUE WITH OUR CURRENT FORM OF HEALTH CARE, WHICH IS A BLEND OF PUBLIC AND PRIVATE INSURANCE, WE MUST PROVIDE CONSUMERS BETTER PROTECTION. WE MIGHT TAKE A LESSON FROM MASSACHUSETTS OR FLORIDA AND REQUIRE THE STATES TO ENACT STATUTES, AS THEY DID, ALLOWING SENIORS TO SWITCH POLICIES WITHOUT PENALTY. WE ALLOW FEDERAL EMPLOYEES THE OPPORTUNITY TO SWITCH PLANS DURING A ONE-MONTH OPEN SEASON WITHOUT PENALTY. SHOULDN'T THAT SAME OPPORTUNITY BE MADE AVAILABLE TO OUR SENIOR CITIZENS? AND, WE MIGHT HEAR TODAY WHETHER WE SHOULD REQUIRE THE STATES TO REVIEW ALL RATE CHANGE REQUESTS THOROUGHLY AND THOUGHTFULLY BEFORE THEY GO INTO EFFECT.

I THANK THE WITNESSES FOR JOINING US TODAY AND LOOK FORWARD TO THEIR TESTIMONY.

Mr. Roybal. The Chair now recognizes Ms. Oakar.

STATEMENT OF REPRESENTATIVE MARY ROSE OAKAR

Ms. Oakar. Thank you, Mr. Chairman.

Mr. Chairman, I want to thank you for holding this hearing. I think it's a very, very timely hearing.

Mr. Chairman, I have always felt that Medigap insurance in general, not in terms of some few plans, is really kind of a ripoff for older Americans. It doesn't cover 80 percent of their catastrophic needs, such as long-term care. It doesn't cover prevention, such as mammogram coverage of cancer screening. It is billed as the kind of coverage that is supposed to fill in the gaps where Medicare leaves off. And as we know, Medicare covers about 45 percent of older persons' needs.

It's a $17 billion industry, as you, I think, mentioned in your comments, Mr. Chairman. And it's no wonder that older Americans wanted to see—at least some of the—the catastrophic bill repealed because most of them had about 2, 3, or 4 other insurance policies, and they didn't understand why there was going—for at least some of them who are not necessarily the rich, as they've been sometimes portrayed, but moderate income individuals who aren't below poverty but between poverty and middle income—why they should additionally be taxed and so forth.

The truth of it is that we ought to put it into all these piecemeal approaches our country spends about 12 percent of its GNP on health delivery where Canada, England, in Germany, in France, Italy and other countries, and the Third World even spend less than 7 percent of their GNP on health insurance, and yet we still have 37 million people without any—most of whom work part-time—and we have all these seniors and disabled people who have inadequate coverage and are paying all this money for these kinds of ripoff policies that they even want to increase.

Mr. Chairman, I'm a member of the Pepper Commission. We're studying various ways to address the fact it's a national scandal that our country is so inadequate in terms of health coverage, which should be an anchor for every American in terms of issues. We really should quit the piecemeal approach and finally get with having coverage for every person in this country. That could be done in a public private way. It could certainly be done with some minimal cost involved.

But when you deal comprehensively and you deal with prevention and you have long-term care, you ultimately save money. We are so backward in this country in terms of our approaches to health care that I for one am going to recommend to the Pepper Commission that we get with it and have beneficiary coverage and long-term coverage for every single American and stop this Medigap kind of phoniness that is going on.

The insurance industry, not everyone, but some of them ought to be absolutely ashamed of themselves for bleeding these seniors who they claim they're lucky to even get this coverage. Well, the coverage is inadequate and costs too much, and so forth. So I'm delighted you're having this hearing. It's prime time to have it and I ap-

preciate the hard work of you, Mr. Chairman, and your wonderful staff.

Mr. ROYBAL. Thank you, Ms. Oakar.

[The prepared statement of Ms. Oakar follows:]

Statement of Rep. Mary Rose Oakar
before the House Select Aging
Subcommittee on Health and Long Term Care
November 2, 1989

THANK YOU, CHAIRMAN ROYBAL, FOR CALLING THIS HEARING TODAY TO ADDRESS THIS URGENT SITUATION THAT SEEMS TO BE RAPIDLY DEVELOPING INTO A CRISIS FOR MILLIONS OF OLDER AMERICANS COVERED UNDER MEDICARE. I KNOW THAT SOME VERY RECENT DEVELOPMENTS PROMPTED THIS HEARING, AND THIS HEARING HAD TO BE PLANNED ON SHORT NOTICE. I COMMEND YOU AND YOUR FINE STAFF, NOT JUST FOR RECOGNIZING THE SIGNIFICANCE OF THE POTENTIAL FOR RISING MEDIGAP COSTS, BUT ALSO FOR ACTING IN A TIMELY WAY AND FOR ASSEMBLING SUCH AN IMPRESSIVE PANEL OF WITNESSES UNDER THE GIVEN CONSTRAINTS. I LOOK FORWARD TO HEARING THE COMMENTS AND QUESTIONS OF MY DISTINGUISHED COLLEAGUES ON THE SUBCOMMITTEE AS WELL AS THE REMARKS AND RESPONSES OF THE PANELISTS GATHERED HERE BEFORE US. SURELY THERE ARE MANY QUESTIONS THAT NEED TO BE ASKED ON BEHALF OF ALL THE MEDIGAP POLICY HOLDERS ACROSS THE NATION.

MR. CHAIRMAN, WE ARE ALL WELL AWARE, THAT THE HEALTH CARE NEEDS OF ALL AMERICANS EXTEND FAR BEYOND WHAT MEDICARE COVERS, EVEN WITH THE MAJOR EXPANSIONS MADE TO THAT PROGRAM LAST YEAR. OF COURSE THOSE OF US WHO ARE ON THE PEPPER COMMISSION, MYSELF INCLUDED ARE CHARGED WITH INVESTIGATING WAYS TO ADDRESS THE CURRENTLY UNMET HEALTH AND LONG-TERM CARE NEEDS OF ALL AMERICANS. YET, RIGHT NOW, MEDICARE RECIPIENTS WHO DO NOT HAVE AN ADEQUATE THIRD PARTY COVERAGE TO SUPPLEMENT MEDICARE ARE PLACING

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THEMSELVES AND THEIR FAMILIES IN SERIOUS FINANCIAL JEOPARDY. SEVENTY PERCENT OF ALL MEDICARE RECIPIENTS CURRENTLY HAVE INVESTED IN MEDIGAP COVERAGE -- SOME 23 MILLION AMERICANS. ADEQUATE COVERAGE IS ALREADY VERY EXPENSIVE FOR MOST OF THOSE WHO CAN AFFORD IT. ON AVERAGE, OLDER AMERICANS SPEND $800 PER PERSON, PER YEAR FOR THEIR MEDIGAP COVERAGE. MEDIGAP INSURANCE HAS BECOME A MAJOR INDUSTRY IN AMERICA, TAKING IN $17 BILLION PER YEAR FROM MEDIGAP CUSTOMERS. MR. CHAIRMAN, GIVEN THIS, I AM ASTONISHED TO DISCOVER THAT THE MAJORITY OF STATES DO NOT REQUIRE FORMAL APPRAISAL OR APPROVAL OF MEDIGAP PREMIUM HIKES BEFORE THEY GO INTO EFFECT. OBVIOUSLY, WITH VIRTUALLY NO OFFICIAL OVERSIGHT AT OF THESE RATE INCREASES THE CONSUMER STANDS TO LOSE. AGAIN, I COMMEND YOU AND YOUR DILIGENT STAFF FOR UNCOVERING THIS DISTURBING FACT. I WILL BE CAREFULLY EVALUATING THE COMMENTS MADE HERE TODAY AS WILL THE CONCERNED AMERICAN PUBLIC.

MR. CHAIRMAN, REPRESENTATIVE OF THE INSURANCE INDUSTRY LAST YEAR TESTIFIED THAT MEDIGAP INSURANCE RATES WOULD GO DOWN WITH THE PASSAGE OF THE MEDICARE CATASTROPHIC HEALTH CARE ACT. THIS SEEMED LOGICAL ENOUGH. HOWEVER, PREMIUMS DID NOT, IN FACT, DECREASE -- THEY WENT UP. EVEN WITH THE ENORMOUS NEW INSURANCE BURDEN TAKEN ON BY THE GOVERNMENT, MOST STATES REPORTED AT LEAST A 25 PERCENT INCREASE IN THEIR PLANS' RATES. MANY WENT MUCH HIGHER. THE AMERICAN PEOPLE WANT TO KNOW WHY THIS IS SO.

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NOW, ACCORDING TO A RECENT ARTICLE IN THE NEW YORK TIMES, WITH THE REPEAL OF CATASTROPHIC, SOME MEDIGAP PREMIUMS WILL SKYROCKET SOME 43 PERCENT. THE COST OF SOME BENEFITS MAY RISE 75 PER CENT. OBVIOUSLY, MR. CHAIRMAN AS YOU POINT OUT, THAT WOULD BE A CATASTROPHE. AMERICANS CAN'T AFFORD SUCH UNCONTROLLED INCREASES AND EVERYONE WILL END UP PAYING FOR THE CARE OF THOSE WHO ARE FORCED, FOR FINANCIAL REASONS, TO GIVE UP THEIR COVERAGE. SO AS I SAID, I WILL BE LOOKING FORWARD TO THE COMMENTS OF THOSE PRESENT TODAY, IN THE HOPE THAT SOME FORM OF ACTION CAN BE TAKEN TO CIRCUMVENT A CATASTROPHE. THANK YOU MR. CHAIRMAN.

Mr. ROYBAL. The Chair recognizes Mr. Skelton.

Mr. SKELTON. No comments, Mr. Chairman.

Mr. ROYBAL. I would like, first of all, to ask unanimous consent that all members be permitted to submit their written testimony, that is, their opening remarks, for the record.

[The prepared statements of Representatives Robert A. Borski, Jim Courter, and Helen Delich Bentley follow:]

Statement of
ROBERT A. BORSKI
at a hearing of
the House Select Committee on Aging
Subcommittee on Health and Long-term Care
Thursday, November 2, 1989
345 Cannon, 9:30 a.m.
"Medigap Insurance: The New Catastrophe"

Mr. Chairman, first, I want to thank you for holding this important hearing to investigate abuses in the "Medigap" insurance market.

Because they must subsist on fixed incomes, older Americans are worried about unexpected expenses of all kinds. They are especially concerned about enormous health expenses because health costs are skyrocketing out of control and they feel increasingly at risk. These unknowing seniors are often preyed upon by unscrupulous and unregulated insurance companies that capitalize on their fears.

For all these reasons, the Medigap insurance market has made a killing with older Americans. Although Congress made great strides in curtailing frequent abuses by companies marketing duplicative policies, seniors continue to buy many useless Medigap policies. The result is that older Americans pay out far more in premiums than they ever receive in benefits. In many cases, policies pay nothing when seniors are truly in need.

What is worse, Mr. Chairman, is that the cost of policies is increasing dramatically -- far above the rate of inflation or above the rate of "medical inflation." With recent legislation to repeal the Medicare Catastrophic Protection Act, many companies made announcements that greater increases in premiums were imminent.

It is unfair that large companies are capitalizing on the fears of senior Americans. While many insurers provide a vital service to seniors, unscrupulous organizations simply take the money and run.

In many states, premium increases are not even regulated through an approval system. Although companies increase premiums annually, officials are not required to demonstrate the <u>need</u> to for an increase or to register increases with the state insurance department. Such simple procedures could provide for a fairer and more honest Medigap market and protect older Americans from potential abuse.

Again, Mr. Chairman, thank you for holding this important hearing. I believe it is critical that we continue to oversee the Medigap market as it evolves. I look forward to the testimony of our witnesses.

JIM COURTER
NEW JERSEY

COMMITTEES:
ARMED SERVICES
SELECT COMMITTEE ON AGING

Congress of the United States
House of Representatives
Washington, DC 20515

REMARKS SUBMITTED BY REPRESENTATIVE JIM COURTER
AT THE HEALTH AND LONG-TERM CARE SUBCOMMITTEE HEARING
"MEDIGAP INSURANCE -- THE NEW CATASTROPHE"
NOVEMBER 2, 1989

Mr. Chairman, I am very pleased that the Subcommittee has called this hearing to focus on reports that the movement to repeal the Medicare Catastrophic Care Act may subject millions of older Americans to dramatic increases in the cost of Medigap policies.

We are all aware that health care costs can be tremendously burdensome to senior citizens, especially to those living on a fixed income. Congress had tried to ease this burden by passing the Medicare Catastrophic Care Act last year. I believe that this legislation offered important protection to seniors. Unfortunately, many individuals lost sight of the benefits in the bill because the supplemental premium imposed such a hardship on many older Americans. For that reason, I supported a repeal of the supplemental premium while retaining as many of the important benefits as possible. The House has voted, however, to repeal all of the Medicare provisions in the new law, and the Senate has moved to greatly scale back the program.

This effort to repeal Medicare Catastrophic Care Act may have an adverse effect that has until now received relatively little attention, and that effect is higher Medigap rates for seniors. According to one newspaper report, private insurers have proposed or have plans to propose premium increases of up to 43 percent to make up for the added benefits they will have to provide if Congress repeals or cuts back the Medicare catastrophic care law.

I am very concerned that sharp increases in Medigap costs will force many seniors to drop their supplemental policies and lose important protection from rising health care costs. As Vice-Chairman of the Subcommittee on Consumer Interests, I am also particularly concerned about reports that some insurance companies may be using the repeal of the catastrophic care program as an excuse to raise rates above the levels necessary to compensate for the additional coverage. I certainly hope these reports are proven false.

I look forward to the testimony of our witnesses today to hear the perspectives of both the insurance industry and elderly consumers on this important issue. I am sure their comments will be helpful for members of the Committee as we continue to consider all of the ramifications of repealing or curtailing the Medicare catastrophic care program.

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OPENING STATEMENT
BY THE
HONORABLE HELEN DELICH BENTLEY
FOR THE
SELECT COMMITTEE ON AGING HEARING
ON
"MEDIGAP INSURANCE: THE NEW CATASTROPHE"
NOVEMBER 2, 1989

I am pleased to be here today to discuss a particularly timely issue of importance to millions of older Americans. The issue at hand is Medigap insurance and the direction we are now headed in light of recent action taken by both Houses of Congress to re-adjust catastrophic health legislation.

Last week, the New York Times reported that Medigap increases of 10-43% could conceivably be levied by the insurance industry in order to compensate for the potential changes in the catastrophic law. As we all know, the House repealed the entire program while the Senate maintained a few select provisions. The conferees are presently meeting so it is anyone's guess as to what the final outcome will be.

Close to 25 million Americans carry additional insurance above and beyond Medicare and I am concerned that these people could face difficult times if insurance industry estimates are at all accurate. That is why I have repeatedly called for quick action to assemble a fair and meaningful package.

Mr. Chairman, I look forward to the testimony of the witnesses. It is my hope that this hearing will be the first step in gauging the full effect that expanded insurance premiums will have on a large segment of our elderly population and also act as a catalyst for action.

Mr. ROYBAL. I would also like to ask unanimous consent to include in the record at this time a copy of the survey that was conducted—that I made reference to. That survey now will be released to the press and become a part of the public record.

Is there any objection?

[No response.]

Mr. ROYBAL. Without objection that will be the order.

[The survey follows:]

Highlights of the Subcommittee Survey

In order to determine on a national basis the degree to which senior citizens have been and will be effected by changes in the costs of their private supplemental coverage, the Subcommittee undertook a telephone survey of the entity within each of the 50 State governments whose responsibility is to regulate the sale of insurance. Appropriate officials in each State Department of Insurance were asked a series of questions relating to recent and approved changes in the cost of Medigap insurance and the scope of regulation of these rates by the States. What follows is a summary of the results of this survey. The summary is based on responses from 44 States.

The first question asked of State insurance regulators was, "What was the range of rate changes in Medigap insurance policies in your State in 1989?" It was the expectation of Congressional, consumer and insurance industry experts that with the implementation of increased "catastrophic" benefits beginning January 1, 1989, including fully paying for long hospital stays and limiting the number of hospital deductibles to one per year, that the cost of private insurance plans which help fill in the gaps of Medicare coverage would decrease. In fact, it was hoped that seniors would be able to use some of the savings they would realize in the the Medigap premiums to help pay for any additional costs they might incur as the result of the Medicare Catastrophic Coverage Act. Contrary to this belief and hope, the Subcommittee survey reveals that in most instances the cost of Medigap insurance increased in 1989. Shockingly, despite the new Medicare coverage, the States reported that increases in policy costs of up to **133 percent**. As Table I. on the following page reveals, every State reported increases in the cost of at least some of the Medigap policies sold there. Maximum increases ranged from 10 percent in Massachusetts to 133 percent in Arizona. **19 of the 35, or well over half of the States which provided a response to this question, indicated that Medigap prices increased up to 25 percent or more.** Interestingly, States with largest number of elderly residents were home to some of the largest increases. For example, in New York some seniors were required to pay 62 percent more for the Medigap insurance. Some seniors in Florida and California encountered premium increases of 50 percent or more.

The second question put to State regulators was, "What is the range of rate changes for Medigap policies in your State for 1990?" It was again expected that costs of Medigap insurance would decrease in 1990 as the Medicare catastrophic insurance benefits were further put into effect. In response to the question, State officials uniformly stated that most insurance companies had not filed their 1990 rates because of the uncertainty surrounding the status of the Medicare catastrophic program. However, the regulators indicated that the majority of companies that have filed with or have indicated to the States, requested rate increases irregardless of the fate of the catastrophic program. The only difference, the States said, would be in the size of such an increase. For example, the major insurer in Massachusetts had requested a 33 percent increase for 1990 assuming that catastrophic benefits would continue. This company has now indicated they will request an additional 44 percent increase if catastrophic benefits are repealed.

TABLE I.
1989 INCREASES IN THE PRICE OF MEDIGAP POLICIES

STATE	PERCENTAGE INCREASE
Alabama	N/A
Alaska	
Arizona	Up To 133%
Arkansas	Up To 20%
California	Up To 75%
Colorado	Up To 15%
Connecticut	Up To 20%
Delaware	Up To 14%
Florida	Up To 50%
Georgia	N/A
Hawaii	
Idaho	Up To 20%
Illinois	Up To 40%
Indiana	
Iowa	Up To 10%
Kansas	Up To 52%
Kentucky	
Louisiana	Up To 75%
Maine	
Maryland	Up To 17.3%*
Massachusetts	Up To 10%
Michigan	Up To 27%
Minnesota	Up To 25%
Mississippi	Up To 75%
Missouri	Up To 120%
Montana	
Nebraska	Up To 12%
Nevada	Up To 75%
New Hampshire	Up To 10%
New Jersey	Up To 43%
New Mexico	
New York	Up To 62%
North Carolina	
North Dakota	
Ohio	Up To 33%
Oklahoma	N/A
Oregon	Up To 60%
Pennsylvania	
Rhode Island	Up To 30%
South Carolina	Up To 15%
South Dakota	Up To 15%
Tennessee	Up To 75%
Texas	Up To 30%
Utah	
Vermont	Up To 12%
Virginia	Up To 35%
Washington	Up To 10%
West Virginia	Up To 18%
Wisconsin	Up To 11%
Wyoming	
Dist. of Columbia	Up To 55%

* For Blue Cross Plans which make up 80-90% of market. Other policies had larger increases but figures not available.

The third and fourth questions put to the States pertained to the degree to which Medigap rates and rate changes are scrutinized. The States reported that the insurance companies are largely free to decide what rates they wish to charge. As is reflected in Table II, nearly two thirds (28 of 44) of the States do not require that changes in rates for group Medigap insurance (that sold to a group of people, such as members of a business or organization) be approved prior to their going into effect. In addition, over a third of the States do not even require group policies to file their rates and rate changes with the State. Over a quarter (12 of 44) of the States reported that rates for individual Medigap policies do not have to be approved before they go into effect. Several States, including Alabama and the District of Columbia do not even require that rate changes be filed with the State.

DOES THE STATE REQUIRE THAT MEDIGAP PREMIUM INCREASES BE FORMALLY APPROVED BEFORE GOING INTO EFFECT?

STATE	INDIVIDUAL POLICIES		GROUP POLICIES	
	YES	NO	YES	NO
Alabama		X		X**
Alaska				
Arizona	X			X*
Arkansas	X		X	
California		X		X**
Colorado	X		X	
Connecticut	X		X	
Delaware	X		X	
Florida	X			X
Georgia	X			X
Hawaii				
Idaho		X		X
Illinois	X		X	
Indiana	X			X
Iowa	X		X	
Kansas		X		X**
Kentucky	X			X**
Louisiana		X		X
Maine				
Maryland		X		X**
Massachussetts	X			X
Michigan	X			X**
Minnesota	X			X**
Mississippi	X		X	
Missouri	X		X	
Montana		X		X
Nebraska				
Nevada				
New Hampshire	X		X	
New Jersey	X			
New Mexico	X			X*
New York	X			X*
North Carolina	X			X**
North Dakota				
Ohio	X			X**
Oklahoma		X		X
Oregon	X			X**
Pennsylvania	X			X**
Rhode Island	X		X	
South Carolina	X			X**
South Dakota	X		X	
Tennessee	X		X	
Texas		X		X**
Utah	X		X	
Vermont	X		X	
Virginia	X			X**
Washington	X			X
West Virginia	X		X	
Wisconsin		X		X
Wyoming		X		X**
Dist. of Columbia		X		X
TOTAL	32	12	16	28

* A limited number of group policies are reviewed.

** Group Medigap policies do not even have to file (inform) the State of changes in premiums. (15 States)

Mr. Roybal. The Chair now will ask the witnesses to make their individual presentations.

The first witness that was called was Mrs. Ethel Weiner, who is a Medicare beneficiary from the State of Massachusetts. She is accompanied here by Ms. Barbara Gloss, who is a Legislative Director for the Massachusetts Association of Older Americans. Their headquarters is in Boston. We are going to ask Ms. Gloss to speak for both. Should the members have any questions of Mrs. Weiner, I am sure that she will be happy to answer them.

However, Ms. Gloss, we'd like to have you then make the presentation. Will you please proceed in any manner that you may desire?

STATEMENT OF BARBARA GLOSS, LEGISLATIVE DIRECTOR, MASSACHUSETTS ASSOCIATION OF OLDER AMERICANS, BOSTON, MASSACHUSETTS, ACCOMPANIED BY ETHEL WEINER, MEDICARE BENEFICIARY, WINTHROP, MASSACHUSETTS

Ms. Gloss. Good morning. My name is Barbara Gloss, and I'm from Winthrop, Massachusetts. I'm 64 years old and in one month I will be a Medicare beneficiary.

I'm here today to testify on my own behalf and on behalf of my husband and my 89-year-old mother who are long-time participants in MEDEX. That's the Blue Cross Medigap policy in Massachusetts. And also Ethel Weiner, age 72, a very close friend of mine, who's with me today and whose story I'll relate to you a little later.

I'm also testifying on behalf of the 18,000 members of the Massachusetts Association of Older Americans, of which I am a member and their Legislative Director.

Every day we hear stories about elderly people on fixed incomes struggling to maintain their health. A living example is Ethel Weiner, who is sitting with me here, who's also from Winthrop. Ethel is always in contact with me because she knows I'm involved in all the senior issues and knows I can usually help her.

But on the issue of Medigap insurance, I'll admit I'm baffled. What can I do? What can any senior do in light of rising premiums?

I met Ethel one day at a local pharmacy where she was picking up a large bag of the prescriptions that she and her husband must take every day. She has severe chronic asthmatic bronchitis which has resulted in heart problems. Her husband is 80 and has very high blood pressure and poor circulation, which brought on a heart attack and a mild stroke.

I invited her to join me for a cold drink and asked her what was in the bag. I was amazed at the medications that were in there, so I kept a list of their names and prices. The list was extensive and the monthly price astounding—$255.69, and those were only for her husband. She takes almost as many in order to keep herself breathing and functioning.

She was so grateful that they had MEDEX-3. That's the most popular and comprehensive Medigap policy and it does pay for the prescriptions. They rely on it to keep themselves well.

The Weiners live on their social security and some savings, which are gradually being depleted. Their out-of-pocket costs—20

percent of their monthly prescription costs in addition to their quarterly premiums—are consuming a large part of their income. The 4- to 6-week period that they have to wait for reimbursement is also an added burden to them.

The likelihood of higher premiums if the MEDEX rates rise further will be completely devastating to this couple who are trying to keep themselves functioning and alive at home. Their costs are barely manageable now. What will happen if the rates go up dramatically, as they are expected to?

Thinking about these impending increases, Ethel made a bittersweet observation. She jokingly said, "Maybe we should drop MEDEX, stop taking all these medications, look for a faith healer or move to Canada."

It really is not a joking matter because stopping these medications would be dangerous to their health.

My husband and I find it challenging to meet our insurance premium, which is $1200 a year for each of us, a rate which we've been told will also go up in January. Our combined Social Security check is $1,000 a month and we have a small pension and some savings. But we consider ourselves lucky that we can do this.

My 89-year-old mother, who lives on a fixed income of about $700 a month, has had MEDEX-3 since the beginning. She decided to gamble and drop her MEDEX-3 coverage, which was around $50 a month, to MEDEX-2, without prescriptions. for $35 a month, anticipating further increases.

I say "gamble" because she's taking a chance that she will remain well. She didn't feel it was sensible to pay this extra premium when she didn't have enough prescriptions each quarter to make the deductible. We pray for her continued good health.

Many others will be forced to make the same choice and reduce their benefits as an alternative to dropping their coverage altogether. A catastrophic illness will force them onto welfare. Elders are becoming paranoid, worrying about future costs.

Earlier this year, Blue Cross filed a request for a 33 percent increase in its MEDEX rate which will raise the average premium for MEDEX-3, the choice of 300,000 subscribers—that's 85 percent of the Massachusetts Medigap market—from $50 to $65 a month. But MEDEX rates could be forced far higher if Congress moves to repeal or drastically cut back the benefits of the catastrophic health care bill.

Blue Cross has notified the State Division of Insurance that if this law is repealed, they will seek a 75 percent increase. This will hike the monthly premium to $86. That's $1,032 a year, in addition to the Medicare Part B premium increase, which will rise to $29 a month. This will force many seniors to drop their insurance.

Currently in Massachusetts, 175,000 seniors cannot afford Medigap insurance at all. As a result, more people will have to rely on emergency rooms for care and the free care pool at hospitals or not seek medical care at all.

Experts have said that the state of the MEDEX system is one of the biggest health care crises facing Massachusetts. Rising costs will lead to greater risks for the most vulnerable elders. I'm sorry, but I don't think it's fair that seniors should suffer because of

rising medical costs and the improper cost containment practices of insurance companies.

Thank you for giving me the opportunity to speak. I will be happy to answer any questions.

Mr. ROYBAL. Thank you, Ms. Gloss.

Mr. ROYBAL. The Chair now recognizes the next witness, who is the President of the United Seniors Health Cooperative here in Washington, D.C. Mr. Firman, the Chair would like to welcome you this morning and ask that you proceed in any manner that you may desire.

STATEMENT OF JAMES P. FIRMAN, PRESIDENT, UNITED SENIORS HEALTH COOPERATIVE, WASHINGTON, D.C.

Mr. FIRMAN. Thank you, Mr. Roybal and members of the committee.

I am pleased to be able to be here today and to represent the views of our organization on the troubling developments that have been revealed so far.

United Seniors is a nonprofit cooperative with 12,000 members in the Washington, D.C. area. Our mission is to help older persons remain healthy, independent and financially secure.

We provide consumer information, publications, counseling services and research to help older people to make informed choices about health care and their health financing options. We do not sell insurance and we are not affiliated with any insurance companies.

United Seniors operates a Health Insurance Help Line for the benefit of our members. By counseling members and working with them on a daily basis, we come face-to-face with the problem that older people deal with when trying to make decisions about supplemental health insurance.

First of all, let me assure you that the testimony we have just heard is representative of the plight of many of our members and perhaps millions of other senior citizens across the country. We hear it from our members, we get phone calls, and we get letters from concerned and confused seniors throughout the United States.

It's no wonder older people are concerned about the rising costs of health care. They're being hit from all sides. Medicare Part B premiums are going up. Out-of-pocket expenses are rising for prescription drugs, dental care, and other services not covered by either Medigap or Medicare. People are very worried about the potentially catastrophic effect of long-term care and wondering whether they should buy nursing home policies.

Now to add to this burden, we learn that many insurance companies are expected to raise their prices on Medigap policies as much as 30 to 50 percent, perhaps even more. These price increases will undoubtedly be a major hardship for millions of seniors.

Are these price increases justified by the facts? In a word, no. The reasons given by the insurance industry, such as rising costs, increased utilization, increased numbers of beneficiaries, do not stand up to close scrutiny.

Rising unit costs of physician and hospital services contribute only in a minor way to the increased cost of Medigap policies. The

key indicator is not health care or general inflation, but what's happening to Medicare-allowable charges. As you know, most Medigap policies pay only the copayment deductibles in Medicare-allowable charges. Since these charges are expected to increase only slightly in 1990—and they range between 1 and 3 percent—copayments should also only rise commensurately.

Increased numbers of beneficiaries have no bearing at all on the issue of rising costs of Medigap policies. More purchasers of Medigap policies will not raise costs, and may, in a modest way, actually reduce overhead and selling charges.

Increased utilization—more doctor visits and tests per patient—is a valid contributor to rising costs of Medigap policies. But the percentage increase in utilization rates is nowhere near the rate expected for Medigap policies.

To understand what is really going on, it is necessary to keep in mind some fundamental and persistent problems with the market for Medigap insurance. Let me review some of the most significant as we see them:

First of all, there's a severe penalty right now for consumers who want to switch Medigap policies. Most policies have a 3- or 6-month waiting period for pre-existing conditions and most seniors have at least one or more chronic conditions for which they are now receiving medical treatment.

This means if an older person wants to drop his/her current policy and buy another one, they either have to go without coverage for 6 months or else pay for two policies until the pre-existing condition clause is over. This is a major and expensive barrier to a competitive market for Medigap insurance.

United Seniors maintains a computerized database of Medigap policies sold to seniors in Washington, DC, Virginia and Maryland. An analysis of these policies for 1989 shows that only 18 percent of the policies have no waiting period, 14 percent have a 2-month waiting period, 36 percent have a 3-month waiting period, and 32 percent require a wait of 6 months before they will reimburse for medical care associated with pre-existing conditions.

A second fundamental problem, in our view, is that it is extremely difficult for consumers to make informed comparisons and choices among competing Medigap plans.

The language in most insurance policies and their marketing literature is often ambiguous and difficult to understand. Each company provides the information in a different format, and to the extent possible, accentuates the benefits and minimizes the limitations of their plan.

Guidebooks are produced by many States but they are simply not enough; they are often voluminous, confusing, and they go out-of-date usually as soon as they have been printed.

Because most seniors don't have a place to turn for clear, accurate and unbiased information, far too many are buying policies without really understanding their coverage.

As Congresswoman Oakar said, far too many are buying more than 1 policy—2, 3 or 4—and wasting their money in this way.

Unfortunately, this general confusion is likely to be exacerbated greatly when the catastrophic benefits are repealed in the next few months.

The third fundamental flaw of the Medigap market is that fear and confusion sells. It is a fundamental premise of insurance marketing that consumers must be led to believe that their potential risks are greater than they actually are. Fear sells. The marketing literature, direct mail letters and advertising campaigns of the major insurance companies demonstrates this clearly. This may make sense as a marketing strategy, but it makes for poor social policy.

The fourth concern that we have is the demand for Medigap policies is surprisingly inelastic. Unfortunately, it appears that the insurance industry has learned some important lessons in 1989 at the expense of consumers. They learned that even when prices are increased significantly, the vast majority of consumers will not drop their coverage. This is due to the difficulties consumers face in comparing and contrasting plans, the financial penalties involved in switching plans, and the growing climate of fear and confusion.

Given this general framework, it is easier to see what is really going on with the anticipated price increases. As we see it, the health insurance companies are seeking to maximize profits at the expense of millions of senior citizens. They are seeking to take advantage of the fear and confusion that characterizes the marketplace. They are unfairly capitalizing on the fact that it is very difficult and expensive for seniors to switch from one plan to another.

What can Congress do in the face of these rising costs and the hardship that older Americans will face? We offer today 4 specific suggestions:

First of all, if the catastrophic bill is to be repealed, we urge you to stick with the Senate version. The extra hospital benefits and the modest cost associated with them are a good deal and should be preserved. The potentially catastrophic cost of a long hospital stay has been one of the most widely used tactics for scaring seniors into buying duplicative or unnecessary health insurance. If the hospital benefit is repealed, we will surely see a major new wave of fear-based advertising.

Second, we recommend that we find a way to ban the sale of hospital indemnity insurance to seniors. In August of this year, United Seniors Health Cooperative reported that many companies were continuing to sell hospital indemnity insurance despite the extended coverage under Medicare. This practice is unconscionable, serves no public purpose and should be banned.

I know of no organization, not even the Health Insurance Association of America, that can justify the sale of hospital indemnity insurance to seniors. By banning such plans, Congress could eliminate a significant portion of the duplicate and wasted coverage that exists.

A third recommendation is that legislation should be passed either at the Federal or State level to require companies to eliminate pre-existing condition clauses for Medigap policyholders who switch policies or buy replacement plans.

If there is going to be a competitive market for Medigap policies, people need to be able to drop one plan and switch to another without serious barriers. Having to pay for 2 plans for 3 months or 6 months or to go without coverage for that period is a very severe penalty. If waiting periods for pre-existing conditions were elimi-

nated for all companies, the overall effect on the industry would be minimal and consumers would benefit significantly.

Fourth, we urge Congress to pass legislation to enable older people to get the help that they need to make informed choices about supplemental health insurance to Medicare.

Informed consumers are essential to the proper functioning of any market. After 15 years of problems and abuses in the Medigap industry, it should be patently clear that State regulations alone cannot ensure that seniors will be able to make informed choices and be adequately protected.

United Seniors believes there is a compelling public policy interest in ensuring that consumers get the help they need to make wise choices. When we leave 29 million people on their own and without assistance to negotiate the health care maze, far too many get hurt.

Congress should pass legislation to establish and fund health insurance counseling and information programs throughout the country. There are several good models currently in existence which could be built upon and expanded. Financing could come from a combination of Medicare funds and State revenues from premium taxes on insurance policies.

In conclusion, the price increases projected by the insurance industry and individual companies cannot be justified on the basis of rising costs. Companies are planning to raise their rates because they think they can get away with it. Insurance companies should not be permitted to profit excessively from the fear and confusion of senior citizens and the difficulties they face in switching plans.

I must say, I agree with Congresswoman Oakar that perhaps we really need a major overhaul of the system. But if, as a Nation, are going to rely on Medigap insurance as part of the Nation's overall social policy for meeting health care costs, conditions in the marketplace have to be improved dramatically. The current regulatory framework has not been enough, and will not be enough.

As long as consumers don't get the help they need in shopping for and comparing plans, as long as there are severe penalties for switching plans, and as long as the sale of useless or substandard policies such as hospital indemnity plans is permitted, these problems will continue and, unfortunately, will get worse.

United Seniors Health Cooperative urges Congress to take the actions we have outlined to help seniors combat these serious problems.

Thank you.

Mr. Roybal. Thank you, Mr. Firman.

Mr. Roybal. The Chair will recognize Mr. Frank.

STATEMENT OF REPRESENTATIVE BARNEY FRANK

Mr. Frank. Thank you, Mr. Chairman.

I apologize, I was at the Whip meeting and delayed, and I have a markup in the Housing Subcommittee, but I did want to particularly welcome the witness from Massachusetts, both as a Member of Congress from Massachusetts and as the son of the President of the organization which Ms. Gloss is representing. My mother is the President of the Massachusetts Association of Older Americans,

and if I want to go home this weekend it seemed to me appropriate that I would acknowledge it.

But I did want to say that I'm really very proud of the work that she does in the organization, and I thank you for having this very important hearing and for including these advocates who do such a good job on behalf of all the people.

I wish I could have participated longer but I did want to express my pride that they are here.

Mr. ROYBAL. Congressman, may I say that now I know why you are such an active member of this committee—you're influenced by your mother. I sincerely hope and know that you will continue to be active and responsive as you have in the past to the needs of senior citizens, not only in your own State, but throughout the country. I'd like to thank you for that.

I think we have a roll call. Supposing we go out and answer the roll call. We will do that and come back as soon as possible, and then we will continue with the next witness.

We are in recess now.

[Recess]

Mr. ROYBAL. The committee will resume its hearing and call upon Mr. John Gilmore, who is an independent Medigap insurance agent from the State of Florida. Mr. Gilmore, will you please proceed in any manner that you may desire.

STATEMENT OF JOHN GILMORE, OWNER AND GENERAL AGENT FOR THE ADVANTAGE GROUP, AN INDEPENDENT HEALTH INSURANCE AGENCY IN NAPLES, FLORIDA

Mr. GILMORE. Good morning, Mr. Chairman, and members of the subcommittee. My name is John Gilmore. I am the owner and general agent of the Advantage Group, which is an independent health insurance agency in Naples, Florida.

I am here today to give you an insider's view of Medicare supplement insurance premiums.

As an independent health agent, I come into contact with a great many senior citizens every week. I also have the opportunity to review many different Medicare supplement insurance plans in the course of my business operation. I personally file most of my clients' claims with both Medicare and their private insurance companies. I see what bills are generated in regards to my clients' health care, how much Medicare pays on those bills, and how much the insurance companies have to pay out on the claims generated from these bills.

I am here to tell you that massive increases in seniors' health insurance premiums, regardless of the financial outcome of the catastrophic coverage program are unwarranted. If that is the case, the only reasonable explanation would be that the elderly had become the victims of price gouging.

Across-the-board increases are nothing new to the insurance industry. In January of this year, Blue Cross and Blue Shield of Florida had a premium increase of 25 percent and AARP experienced a premium increase of about 40 percent. Keep in mind that these increases came about as the Catastrophic Coverage Act's benefits were starting to go into effect for Part A of Medicare. With the po-

tential repeal of some of those benefits an excuse may be given to those insurance companies to continue their escalating premiums. The excuse, however, is not a valid one for several reasons.

First, the repeal of prescription drug benefits would have little to no effect on my clients. I filed very few claims for drugs to insurance carriers which would total anywhere close to the proposed annual deductible of $600.

Second, escalating costs for physician services has little effect on those insurance policies which provide for only the 20 percent copayment amount on what Medicare approves.

It has been my experience that those basic types of Medicare supplements make up the vast majority of private health insurance protection for senior citizens. Repeal of the copayment cap would have very little effect on these basic policies. In fact, I filed less than 3 claims where the 20 percent copayment would have reached the cap of $1,370 had it been in effect in 1989. There was far more liability for those charges which were above the Medicare approved rate but which most supplemental insurance does not cover anyway.

Third, the repeal of the unlimited hospital stay and single calendar year deductible on Part A benefits would have affected only one of my clients in 1989. With the Prospective Payment System in effect—DRGs—hospital stays are kept at a minimum anyway. I see little liability for an insurance company if the DRGs are not going to let the patient stay in the hospital for an extended length of time in the first place.

If the insurance industry is going to use the repeal of the catastrophic bill as an excuse to raise premiums on their insurance plans, I'd make a suggestion to them: Look at other ways of saving money. One sure way to cut down costs is to stop paying outrageous first-year commissions on some policies. On some policies, 75 percent of the first-year premium paid by the elderly policyholder goes strictly to the seller in commission. That is just not right.

In addition, many companies are inefficient in the way they process claims. They could save plenty by improving.

Substantial increases in Medicare supplement insurance premiums have far-reaching effects on our senior citizens. One typical example would be that of an elderly couple I will call Mr. and Mrs. Beats. This couple has an annual income of less than $7,000 a year. They are aware of the fact that Medicare does not pay all the medical bills. They told me Tuesday that if their insurance premium goes up much farther they will have to drop their coverage and, quote, "Take their chances." This would cost them their peace of mind, which is one of the primary benefits of health insurance in the first place.

I worry about those seniors with chronic illnesses who will be forced to keep their present coverage no matter what the cost. I shudder at the thought of thousands of our elderly desperately trying to find where they can cut their already trimmed budgets to pay for insurance costs each month. I am frightened, and they will experience the fear also.

I believe that as these insurance rates go up, our senior population will go bargain hunting. Pre-existing condition clauses will

force many of our elderly to hold their breath after they switch their coverage to cheaper and probably inferior insurance.

In conclusion, I would like to say that a laissez faire position in regards to Medigap insurance does not work. This has become evident over the past few years with long-term nursing home insurance with its atrocious sales practices and loophole-riddle policies.

Insurance companies should be held accountable for their premiums and not just to the general public and a few of the States, but to the Federal Government as well. They should have to prove why they need rate increases, and if it is due to mismanagement or exorbitant profits, then those increases should be denied.

As an insurance agent my job is to serve the public for a profit. The order in which I state that is very important. One serves the public first and the profit is naturally generated. I hope that my industry will keep that in mind. I hope they are not reversing the order.

Thank you.

Mr. Roybal. Thank you.

The Chair will now recognize Ms. Linda Jenckes, who is the Vice President of the Health Insurance Association of America. They are stationed right here in Washington, D.C.

Ms. Jenckes, we are glad to have you with us today and ask you to proceed in any manner that you may desire.

STATEMENT OF LINDA JENCKES, VICE PRESIDENT, FEDERAL AFFAIRS, HEALTH INSURANCE ASSOCIATION OF AMERICA

Ms. Jenckes. Thank you, Mr. Chairman.

I am here today in response to your request for our views on why premiums for private Medicare supplemental policies have increased this year.

Since the Congress is currently considering the repeal in whole or in part of the Medicare Catastrophic Coverage Act of 1988, I will also offer some general comments on the likely effect of such action and what effect in essence it would have on private Medicare supplemental premiums in 1990.

I'd like to begin by saying that we understand and empathize with your interest in the effect of recent and potential changes in Medicare on senior citizens. Like you, when the Medicare catastrophic benefit was enacted, we were besieged with inquiries from confused senior citizens wanting to know how their benefits, taxes and Medicare supplement premiums would be affected.

We are experiencing the same phenomenon again, now that the House and Senate have voted to at least partially repeal the Medicare catastrophic benefits.

In addition, since the House and Senate are at this point not in agreement on just what is to be done with regard to catastrophic, our member companies, with 1990 just two months away, are anxiously awaiting a final outcome so they can work with State insurance regulators to determine the appropriate benefit and premium changes in their supplemental policies for next year.

I'd just like to say that in 1989, we feel that the transition period worked extremely well and you have our commitment to work again with you and other committees, as well as beneficiaries, to

assure that that transition proceeds in 1990 regardless of Congress' deliberations on the fate of the law.

But until we know definitely how Medicare benefits will change in 1990, we cannot calculate precisely what effect those changes will cause on the cost of our supplemental policies.

If I may, I'd like to turn now to an explanation of why, despite the implementation of the first phase of the Medicare Catastrophic Coverage Act, most premiums for private Medicare supplemental insurance rose this year.

One might expect that with the Federal Government assuming a larger share of health care costs for Medicare beneficiaries under the new benefit, private insurance costs would have gone down.

The short answer to that question is that in 1989 the new benefit provided by the first increment of Medicare Catastrophic is much less than the predicted increases in both the cost and volume of claims for Medicare supplement policies.

According to the Health Care Financing Administration, the full actuarial value in 1989 of the new catastrophic hospital and skilled nursing facility benefits is $65 a year per beneficiary. Taken by itself, this assumption of additional financial responsibility by the Medicare program would have permitted a premium reduction in the range of 8 to 12 percent in the average Medicare supplement policy.

However, a greater number of premium increasing factors were also at work. For example:

For 1989 the Medicare Part A deductible was increased from $540 to $560. Since about one-quarter of the 32 million Medicare beneficiaries can be expected to enter a hospital each year, this increase in the hospital deductible translated into a $9 or a 2.5 percent increase in supplemental premiums.

Additionally, effective in January of this year, Congress approved a 3 percent increase in the prevailing charges paid to participating primary care physicians and a 1 percent increase for other participating physicians. Medicare supplement policies pay the 20 percent of allowable charges for which beneficiaries are liable. Thus, the increase in allowable charges increased costs for both Medicare and Medicare supplement policies.

Some insurers deferred premium increases that were needed in 1988 while waiting to find out exactly what type of catastrophic legislation Congress would eventually adopt. The net effect of waiting, for those companies, was to increase the premiums they needed in 1989.

Another unusual occurrence that significantly affected the premiums of some insurers in 1989 was their switch from a single rate for each of their standard Medicare supplemental policies to something called area-specific rating of these policies.

The effect of this pricing strategy was to sharply increase premiums in parts of the country where health care costs are the highest, while areas where costs are relatively low experienced much smaller or, sometimes, no increases.

We understand that premiums for the American Association of Retired Persons Medicare supplements increased by 75 percent in portions of California, Texas and Louisiana, but there were not premium increases for the same benefits in all of New England.

However, and of perhaps greater importance than any of the cost-increasing factors that I have discussed, even when combined, had less of an effect on 1989 premiums than the pervasive impact of rising medical care costs.

The majority of claims dollars paid out by Medicare supplemental insurers, again, are for the 20 percent of Medicare-approved Part B charges which are the beneficiaries' responsibility to pay.

That is a portion of the program, Mr. Chairman and committee members, that was not in effect this year.

Due to rising physician fees, more services being provided the elderly, the higher cost of new technology and the fact that many procedures which used to be done in hospitals are now done in doctors' offices, Medicare Part B payments have doubled in only 5 years from $13 billion in 1983 to $28 billion in 1988—a compounded rate of 16 percent a year.

Because Medicare supplemental policies cover the beneficiaries' 20 percent copayment, we are experiencing similar increases in claims payments.

I would like to emphasize that Medicare supplemental premiums are increasing because companies are experiencing increases again in both the cost and volume of medical claims which exceed savings from the first phase of the Catastrophic Act. Annual increases in claims cost per beneficiary in the order of 16 to 18 percent are common.

Discounting situations where insurers switched again to area specific-premiums or had deferred rate increases needed in 1988 until 1989, the average Medicare supplemental premium increased for this year—1989—appears to be about 10 to 12 percent.

I regret that I cannot provide specific information on this point because in fact the Health Insurance Association doesn't have any. As a trade association comprised of competing companies, we do not gather data on existing or prospective premiums of our members because to do so might cause us to run afoul of the antitrust laws aimed at price-fixing.

I understand, however, that the General Accounting Office has been gathering specifics on both 1989 and 1990 Medicare supplement premiums from a number of our companies and will be able to help with detailed information on how insurance premiums reflect first the enactment and now the prospective repeal of the Medicare Catastrophic Act.

I have tried to outline the factors that affected supplemental premiums in 1989. But let me offer just a few quick general observations on what may happen in 1990 by pointing again to the pattern of increased expenditures of Medicare Part B benefits.

In 1990, if the Medicare Catastrophic Coverage Act remains unchanged, Medicare will cap at $1,370 the annual beneficiary liability for 20 percent of allowable charges. This assumption of financial burden by the government has been estimated by the Health Care Financing Administration actuaries to have an annual value of $94 per beneficiary and would be reflected by appropriate reductions in premium. However, again, there will be an increase in the Part A deductible; this time it will be rising from $560 to $592.

In addition, we see no end to the trend of rising Part B expenditures, a factor that will cause a larger number of beneficiaries to

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incur higher costs beneath the $1370 catastrophic cap on beneficiary cost-sharing. These increased costs will have to be assumed by supplemental insurance.

Lacking actual data from member companies, the HIAA can only guess about 1990 supplemental premiums. If you will accept our unofficial estimate as such, we think that the following alternative average premium increases for Medicare supplemental policies can be expected:

Let us presume that the Medicare Catastrophic benefit remains unchanged, Part A would stay as it is; Part B—in other words, the cap would go into effect the prescription drug benefit, we would presume that the average increase in supplemental premiums would be in the area of 7 to 12 percent.

If the 1989 benefits—in essence, just the hospital side or Part A benefits were retained—but 1990 and 1991 benefits, eliminating the $1370 cap and the prescription drug benefits, we would predict somewhere in the neighborhood of a 15 to 20 percent increase in premiums.

If Medicare catastrophic was totally repealed, even the hospital portion of it that went into effect this year, we would presume something in the neighborhood of 20 to 25 percent premium increases.

Mr. Chairman, and committee members, I hope this statement has been helpful.

What I'd like to do is also insert as part of the record our updated brochure on Medicare Supplemental Insurance. The model was worked on with consumers, the Department of Health and Human Services, the National Association of Insurance Commissioners, and we feel offers the best general approach to best understanding a very complicated Medicare program, and particularly when it's at this stage of implementation over a 3-year period of time.

Again, we stand ready to work with you and beneficiaries to make sure the transition in 1990 is as smooth as it was this year.

Thank you.

[The brochure follows:]

HIAA

Health Insurance Association of America

THE CONSUMER'S GUIDE TO MEDICARE SUPPLEMENT INSURANCE

This booklet provides practical information about Medicare and the use of private health insurance to help you pay for the costly expenses associated with illness requiring hospitalization and surgery.

In these pages, we will show you how supplemental private policies can fill the gaps in Medicare. The idea is to give you enough understanding of these government and private insurance programs to enable you to deal more confidently with the choices available to you.

The booklet includes "plain language" definitions of common private health insurance and Medicare terms on pages 12 and 13. You may want to refer to them as you read through the material for better understanding.

A Consumer's Bill of Rights

If you are thinking of buying a Medicare supplement policy, use this bill of rights as an aid in making your purchase decision. A Medicare supplement policy should cover the following gaps in Medicare coverage. Read the policy carefully before you buy it.

What are my rights as a consumer?

1. A Medicare supplement policy that does not duplicate coverage provided by Medicare.

2. The option to purchase coverage for deductible amounts.

3. Benefits for expenses related to health conditions you may have had before purchasing the policy once the policy has been in force for six months (or less).

4. Benefit increases that keep up with Medicare cost-sharing amounts.

5. A Buyer's Guide for this type of insurance.

6. An Outline of Coverage explaining policy benefits.

7. Full refund if you return the policy within 30 days. So read it carefully as soon as you receive it.

What does Medicare cover now?

The Medicare information that follows is effective January 1989. It will change from year to year.

Medicare was never intended to be an all-inclusive health insurance program. Even with the new changes in the Medicare law that was passed in 1988, Medicare does not cover all health care costs. It was designed mainly to relieve people aged 65 and older of part of the costs associated with hospitalization, surgery, home health care and skilled nursing care. In other words, Medicare partially covers expenses stemming from short-term acute medical conditions not long-term, chronic conditions. Coverage was later extended to certain individuals under age 65 who are disabled or suffer from end-stage renal disease. After age 65, all persons eligible for Social Security also become eligible for Medicare whether they retire or choose to continue working.

Medicare does not cover all health care costs.

Medicare is divided into two parts—Part A (hospital insurance) and Part B (medical insurance for physician and surgeon charges in and out of a hospital and for medical supplies). Part A is available without charge to everyone who is automatically eligible for it. People who are not automatically eligible must pay a monthly premium for its coverage, currently $156 per month. To find out if you are eligible, check with your local Social Security office. Medicare Part B is optional medical insurance if you are automatically eligible for Part A. Currently, the premium is $27.90 for Part B, but that amount will change each year. An additional $4 per month is charged beneficiaries to help pay for the new Medicare catastrophic coverage.

For a more complete description of Medicare coverage and costs, obtain a copy of "Your Medicare Handbook," available from any Social Security office.

What is included in Medicare Part A?

Parts A and B help pay for many doctor, hospital, skilled nursing and laboratory services.

Medicare hospital insurance (Part A) pays for many of the services you receive in a hospital or skilled nursing facility. It also can pay for home health care and hospice services under certain conditions. If you are hospitalized, Medicare covers the charges customarily associated with a hospital bill, such as for a semiprivate room, drugs and laboratory and radiology services. You will be entitled to unlimited hospitalization for approved inpatient care after you pay a single annual deductible. The deductible is the amount you must spend before Medicare begins paying for inpatient services covered by the program.

Medicare Part A also helps pay for up to 150 days of approved skilled care in a skilled nursing facility that is approved by Medicare. Skilled nursing care is different from intermediate or custodial nursing care. Medicare does not cover intermediate or custodial care in a nursing home, nor do most private Medicare supplement policies. Many insurance companies offer long-term care policies that do, however. Long-term care insurance is relatively new and is worth investigating.

Intermittent home health care is covered when care is needed no more than five days per week. Services typically include therapy, skilled medical services and supplies and equipment provided by Medicare-approved home health care agencies.

Medicare Part A can help pay for hospice care if a doctor certifies that a patient is terminally ill, a patient chooses to receive care from a hospice instead of standard Medicare benefits for the terminal illness and care is provided by a Medicare-certified hospice program.

Part A—Medicare Hospital Insurance

Service	Medicare Benefits	Your Cost
Hospitalization	Unlimited	$560 deductible annually
Certified skilled nursing facility	The first 150 days each year	$25.50 per day for the first 8 days plus the cost after 150 days
Intermediate and custodial care	Not covered	Full cost
Intermittent home health care	Fully covered	None
Continuous home health care (beginning 1/1/90)	38 consecutive days; may be renewed under special circumstances	Care after 38 days if Medicare coverage is not renewed
Hospice	210 days; may be extended by recertification	Cost after 210 days if not recertified
Inpatient respite care	95 percent of cost of care up to 5 consecutive days	5 percent of cost of care

What is included in Medicare Part B?

After you have paid an annual deductible, the program will pay for 80 percent of additional approved medical charges; you are responsible for 20 percent of those charges plus any amount in excess of what Medicare considers allowable. Medicare determines what is an allowable charge. It could be considerably below a physician's

Private insurance can cover gaps in Medicare coverage.

regular fee. Some physicians accept that figure as full payment, but others do not.

Ask your physician or surgeon if he or she will accept Medicare assignment—that is, accept what Medicare recognizes as approved charges as payment in full. If not, your out-of-pocket expenses will be the total of the calendar year deductible, the 20 percent coinsurance and that part of the doctor's charges that exceeds Medicare's definition of an allowable charge.

Aside from physician and surgeon benefits, Medicare Part B helps pay for a number of other benefits such as diagnostic tests, medical supplies, laboratory tests and certain ambulance services. It also covers emergency room and outpatient clinical services. Most of these are subject to the deductible and 20 percent coinsurance. But remember, you do not pay the Part B deductible every time you use Medicare-approved services—you pay it only once per calendar year.

Where are the gaps in coverage?

Regarding the types of expense covered by Medicare, the gaps are indicated under the columns labeled "Your Cost" in the summaries of Part A and Part B Medicare. In addition, there are types of medical expense not covered by Medicare. These include:

- Skilled nursing care in facilities not approved by Medicare. Only about one-third of the skilled nursing home beds in the United States are in facilities approved by Medicare.
- Intermediate and custodial nursing care.
- Most out-of-hospital prescription drugs before 1991.
- Private duty nursing.

Medicare Part B—Physician and Other Provider Services

Service	Medicare Benefits	Your Cost
Physician and other services	80 percent of approved charges exceeding $75. An out-of-pocket limit on approved charges you must pay begins in 1990. The limit in 1990 is $1,370	$75 deductible annually plus 20 percent of additional approved charges and charges exceeding approved charges for doctors who do not accept assignment
Respite care*	80 hours per year	The cost after 80 hours per year
X-ray screening for breast cancer*	Up to $50 per X-ray screening every other year	20 percent of charges and all costs if incurred less 24 months after a previously covered X-ray screening
Some prescription drugs, antibiotics, intravenous and immunosuppressive drugs*	After a $550 deductible, 80 percent of additional charges for home intravenous drugs and 50 percent of additional charges for immunosuppressive drugs (after first year after transplant)	The first $550 plus 20 percent of additional charges for home intravenous drugs and 50 percent of additional charges for immunosuppressive drugs (after first year after transplant)
All prescription drugs and insulin**	Coinsurance for approved charges exceeding calendar year deductible. Coinsurance is 50 percent in 1991; 60 percent in 1992; and 80 percent in 1993	The deductible, the percentage of excess not paid by Medicare and charges exceeding approved amount. The deductible is $600 in 1991; $652 in 1992; and undetermined thereafter

**Beginning 1/1/90 **Beginning 1/1/91*

What private coverage is available?

First, let us face an uncomfortable reality. As people age and become more prone to illness, the cost of insuring against illness goes up. So, assuming you have some time before you become eligible for Medicare, let us examine what is available. There is a variety of coverage to help you lessen your financial risks due to illness or injury.

The coverage your employer provides may continue after you retire.

Group Insurance

Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which became effective on January 1, 1983, Medicare beneficiaries and their spouses who continue their group insurance coverage after age 65 have a new option.

Previously, when an employee became eligible for Medicare at age 65, an employer could eliminate any benefits covered by Medicare, or, in certain cases, offer a general policy to supplement Medicare coverage. In effect, Medicare would always be billed first as the primary payer.

Now, employers of 20 of more persons must offer employees and their spouses the opportunity to remain under the regular company health plan, with Medicare supplementing company benefits. If an employee elects this option, the employer plan must pay first—for all benefits covered under the employer health plan—before Medicare is billed. In most instances, it is to the employee's economic benefit to accept continued employer coverage.

Be sure to check with your employer for a detailed explanation of this option.

As you plan to retire, check the group health insurance plan provided by your employer or your professional or membership organization. Many group plans continue some coverage after a member becomes eligible for Medicare, with some employers paying part or all of the costs.

If that is the case with your plan, examine the

benefits (perhaps with someone in your employee benefits office) to see if they cover the gaps discussed here. If they do, consider continuing your group health insurance after you retire. It may provide greater benefits than would be available to you otherwise, and group insurance benefits are often less expensive than if you purchase similar benefits as an individual.

Other plans may permit members to convert from group to individual coverage when they terminate their employment. This may be to your advantage because you do not have to be in good health to qualify for coverage.

Another aspect to consider: find out if there is a health maintenance organization (HMO) in your area that accepts Medicare enrollees. If there is, your employer usually gives you the option of joining it as one form of group health insurance. An HMO is a community health organization that provides facilities, professional services and supplies for an annual fee.

It is likely that your current group insurance, if it can be continued or converted when you become age 65, will serve as an adequate supplement to Medicare. If you do not have a group plan or if your present plan is either inadequate or will not carry over, you must then consider purchasing some type of individual insurance.

You may be able to convert your individual coverage to a Medicare supplement policy.

Individual Insurance

Medical Expense Policy

A hospital or medical expense policy you purchase before you are eligible for Medicare reimburses you for the expenses you incur for hospitalization and other medical treatment. Examples of this type of coverage are hospital-surgical, major medical and comprehensive health insurance policies.

If you are under age 65 and covered by an individual medical expense policy, your coverage will usually change or end when you turn age 65. In some instances you may be given the opportunity to convert your coverage to a Medicare supplement policy. (See the discussion of Medicare supplement policies, page 11.)

Under conversion, you will be issued a new policy by the same insurer, with benefits that

relate to Medicare's gaps. This may be to your advantage because you will not have a break in coverage, you will not have to be in good health to qualify and your new policy will not make you wait to be covered for health conditions you already have if they were covered under the medical expense policy.

Different policies may offer you different options when you turn age 65. It is very important for you to check your policy carefully to determine what your benefits will be when you become eligible for Medicare, although federal law and state regulations prohibit Medicare supplement policies from containing benefits duplicating Medicare.

Carefully match a policy's benefits to your particular needs.

Hospital Indemnity Policy

This type of policy pays you cash benefits in a specified amount for each day you are hospitalized. It is not a substitute for more comprehensive medical coverage, but the cash benefits, which can be used for any purpose, may be helpful in meeting out-of-pocket expenses that are not covered by other insurance. Insurers issue this kind of policy because they know that the more serious the illness, the greater the chance that Medicare benefits together with Medicare supplement policies will still leave uncovered bills.

Hospital indemnity policies frequently are available directly from insurance companies by mail, as well as from insurance agents. As with any product that offers many choices, these policies require care in matching the plan to your needs. Because their benefits are in fixed dollars while health care costs continue to increase, you might consider increasing periodically the amount of daily benefits under this type of coverage. And, as is the case with most individual insurance policies, they may contain a preexisting condition limitation.

Some policies also may contain an elimination period, which means benefits will not be paid until after you have been hospitalized for a specified number of days. When you apply for the policy, you may be allowed to choose among two or three alternative elimination periods, with different premiums for each.

Some nursing home or long-term care policies are similar to hospital indemnity policies, except that they pay cash benefits for each day you are confined to a nursing home. The cash benefits may differ depending on whether you are receiving skilled nursing care, intermediate care or custodial care. HIAA has published a booklet on this type of insurance called *The Consumer's Guide to Long-Term Care Insurance*.

Medicare Supplement Policy

This type of policy, also sometimes called Medigap, is specifically designed to cover many of the gaps in Medicare coverage. It is available only to people who are aged 65 or more.

Medicare supplement policies must meet federal and state standards.

All Medicare supplement policies must cover certain gaps in Medicare coverage. In addition, some policies may cover the Part A or Part B deductible or both, and some may cover services which Medicare does not cover at all.

But there are some expenses that even Medicare supplement policies probably will not pay for, such as dental or foot care, eyeglasses, hearing aids, routine examinations or cosmetic surgery. Always check policy exclusions carefully. It is just as important to know what is not covered as to know what is.

Are there standards?

All state laws require that Medicare supplement policies meet certain standards. Those that mainly affect you are listed in the Consumer Bill of Rights in the front of this booklet.

General state insurance laws protect the confidentiality of the records and claims of all beneficiaries, require prompt payment of claims, govern the conduct of any agent who may call on you and require that the advertising you may receive has been reviewed by the state insurance department. Also, there are criminal penalties for false statements or misrepresentations made to you by those selling insurance who say they or

their insurance products are endorsed by the federal Medicare program. If you feel that there has been this kind of misrepresentation, contact your state insurance department or Medicare officials.

Any questions or doubts you have about your state's laws should be directed to your state insurance department. The department also can help you with questions about policies, insurance companies or agents.

What health insurance terms should I know?

Health insurance policies can appear confusing. Because they are legal contracts, they employ precise legal language. We cannot tell you in this booklet all the terms and what they mean. But we can describe in everyday language the concepts some terms spell out legally. If a concept is used by both Medicare and private insurance companies, it is marked by an asterisk.

- **Approved charge**—This is the amount of a provider's fee that Medicare will recognize in calculating its benefits. If a provider does not accept assignment of your Medicare benefits and charges more than Medicare's approved charge, you must pay the difference. The payment does not count toward Medicare deductibles or benefits.
- **Benefit maximum**—The most the policy will pay for a given benefit. A benefit maximum can be expressed either as a length of time (for example, 38 days of continuous home health care) or as a dollar amount (for example, $350 for a certain medical procedure).
- **Conditionally renewable**—The company agrees to continue insuring you, except for specific reasons stated in the policy. This does not protect you as well as a guaranteed renewable provision, but it is more protective than if the policy is renewable solely at the option of the company.

- **Coinsurance (or copayment)**—The portion of a medical expense you must pay, with the insurance policy (or Medicare) paying the rest. Your coinsurance might be a dollar amount (such as under Medicare, the $25.50 you must pay for each of the first eight days of skilled nursing care), or a percentage of the expense (such as 20 percent coinsurance of the allowable physician's charge under Part B of Medicare).
- **Deductible** —An initial amount of the medical expenses you must pay before the insurance policy (or Medicare) begins to pay benefits.
- **Elimination period**—This usually applies to hospital indemnity policies, and means that benefits may not be paid for the initial period of hospitalization. Elimination periods vary, so you have a choice: the longer the elimination period, the lower the cost of insurance. In that case, you are less likely to receive benefits for a short period of illness.
- **Entrance age**—The age up to which the company will sell you a policy. Entrance ages vary considerably from company to company and some policies can be bought at any age.
- **Guaranteed renewable**—The company agrees to continue insuring you up to a certain age as long as you pay the premium; and it cannot raise your premium unless it raises premiums for a particular group, such as everyone in your geographic area with the same kind of policy. Some policies are guaranteed renewable for life.
- **Lifetime maximum**—Some plans limit the total benefits they will pay over the life of the policy.
- **Preexisting condition**—A health problem that you had prior to becoming insured. Policies with preexisting condition limitations will not pay benefits for treatment of prior health problems for a specified period of time, usually six months or less.
- **Renewable at company option**—The company reserves the right to stop insuring you. You cannot be cut off from receiving benefits under the policy in the midst of an illness, however.

Questions we hear most often

Here are some typical questions that people ask about supplementing Medicare coverage with private insurance.

? Why do I need a supplemental health policy? Doesn't the new catastrophic Medicare legislation give me enough benefits?

The changes in the Medicare law are phased in over a period of years, so you may want to think in terms of what you may need today and what you may need a couple years from now. Under the new law, Medicare coverage of skilled nursing care is limited to 150 days per year. Home health care has been extended somewhat, but it, too, is limited, in this case to 38 consecutive days. Even with the changes, there are copayments and deductible amounts which do add up. For example, we can predict that more than 7 million older people will be hospitalized for at least one day during each year for which they will incur a bill of at least $560. You will want to take all these facts into account when determining the amount of coverage you need.

? What is the first contact I should make?

Your local Social Security office—at least several months before you reach age 65. At work, contact your employee benefits person. Your group health insurance will be continued if you still are working; it also may be maintained if you choose to retire.

? What if my group insurance can be continued?

Check the benefits to be sure there are no big gaps left between your plan and Medicare. If there are not, most of the problem is solved. Remember, if you or your spouse are over age 65 and continue to work, and the employer has more than 20 employees, the employer plan will

pay your health bills, with Medicare as a back-up. Check with your employer for details.

What do you mean, most of the problem?

Even with the major health protection gaps covered, there will be out-of-pocket expenditures. Sometimes, these can be financed from current income or savings. But if it looks as if these could be a burden, consider an individual policy or a long-term care policy to cover the extras. No policy will cover all of the gaps.

What if I cannot continue my group coverage—or if continuing does not seem to be helpful?

There are basically three kinds of individual insurance plans you can buy (although other forms of limited coverage are available): a medical expense policy, a hospital indemnity policy and a Medicare supplement policy. You may want to investigate buying a long-term care policy.

How could I look into them?

Policies are available through independent brokers and agents, as well as by mail from many insurance companies.

If hospital indemnity policies pay only when you are hospitalized, would they duplicate Medicare coverage?

Yes, to the degree that these hospital benefits exceed Medicare's hospital deductible. But they pay benefits only upon hospitalization and they pay their benefits in cash that you in turn can use to pay for any out-of-pocket costs that develop. Therefore, such policies are not considered duplicative by state insurance regulators.

Which of the three types of individual plans is better?

Each has its advantages, although a Medicare supplement policy often pays more benefits and is more comprehensive. The Medicare supplemental type of policy generally covers the obvious gaps in Medicare and extends benefits beyond Medicare levels. Also, because it pays benefits as a percentage of the actual costs, it tends to respond automatically to inflation with higher benefits. This, in turn, is naturally reflected in periodic premium increases.

Hospital indemnity policies pay benefits in cash, but you have to keep an eye on rising health care costs. If they outrun your coverage, you might have to add coverage to your existing policy or buy an additional policy. Hospital indemnity policies are not substitutes for more comprehensive medical coverage.

Long-term care insurance policies usually pay for skilled, intermediate or custodial care in a nursing home. Also, policies usually cover home health care services such as skilled or nonskilled nursing care and homemaker and home health aides. Almost all long-term care policies are called indemnity policies, paying a fixed dollar amount per day for covered services. No policy, however, provides full coverage for all expenses. Ask a reputable insurance agent or call the insurance company directly for more information. Also, ask your friends and neighbors about their policies and if they have been satisfied with their coverage.

What about the elimination period sometimes contained in hospital indemnity policies wherein benefits are not payable immediately? Is it best to get first-day coverage in the hospital indemnity policy I buy?

Not necessarily. Decide if you are able to balance the benefits you want against the premiums you can afford. You may, for example, be able to pay for a short stay in a hospital out of your own pocket.

If I have enough supplemental coverage, should I consider dropping the Part B section of Medicare?

No. Part B premiums are subsidized by the federal government, which means that you get more for your dollar than through any other approach. Private health insurance is designed to dovetail with the Medicare program, not compete with it.

Are nursing home benefits included in supplemental health insurance policies?

Generally not under Medicare supplement and hospital indemnity policies but such coverage would be provided under long-term care policies. Most policies are not intended to cover long-term custodial care. If the nursing facility provides "skilled care," benefits may be provided. Many insurance companies are responding to the growing demand for nursing home long-term care insurance. You may wish to explore the increasing number of options in this area.

Is private duty nursing in the hospital included in any policies I might buy?

Check the policy carefully. This is an option available in some policies.

Is cancer insurance considered supplemental to Medicare?

Only to the degree that the benefits payable are available to help pay the medical expenses not paid by Medicare. Cancer-only policies, however, do not qualify as Medicare supplement policies.

Can I buy more than one policy to supplement Medicare and have both of them pay me?

That depends. You should check the policy carefully before you buy to see if coverage is reduced if you have other insurance. It is in your own best

ınterest to avoid insuring yourself too heavily. That happens when benefits exceed actual medical expenses. Obviously, the benefits payable under a second policy are available to cover expenses not covered by either Medicare or your first Medicare supplement policy and such expenses could be extensive. If your benefits are not adequate, try to buy only the additional coverage you need.

What else can I do to protect myself?

- Start a health emergency fund of your own. There always will be some out-of-pocket expenses associated with an illness or injury, even with Medicare and a sound supplemental health insurance plan. If possible, keep your emergency fund in a joint savings account so someone else has access to it in the event you are incapacitated.
- Take your time. Do not let a brief enrollment period pressure you into buying a policy.
- Your choice of physicians and surgeons should depend on your confidence in their skills. But do not hesitate to ask them about their fees and how they are to be paid. Remember to ask whether they will accept assignment of Medicare benefits. In this case, they cannot charge you greater than Medicare's allowable charges. It will be less costly for you in the long run to have this arrangement with your doctor.
- If you continue to work past age 65, you and your Medicare-eligible spouse may choose to remain covered by your employer's group health plan. Check with your employer for the advantages of doing so.
- Know with whom you are dealing. A company must meet certain qualifications to do business in your state. This is for your protection. Agents must carry proof of state licensing. If the agent

cannot show proof, do not buy from that person. A business card is not a license.

- Other helpful booklets include "Your Medicare Handbook," available from any Social Security office and "A Guide to Health Insurance for People with Medicare," available from the Health Care Financing Administration, state insurance departments and companies selling Medicare supplement policies.
- Coverage of skilled nursing services, either in a nursing facility or at home, is available under Medicare and some insurance policies—if you meet the qualifications—to help you avoid the high cost of hospitalization.
- Your choice of supplemental health insurance should be made carefully. Investigate, weigh benefits, compare, ask questions and do not be satisfied until you get answers you understand.
- Claim forms should be made out carefully and completely. If they are not, delays in processing may cost you money and concern.
- Do not buy more insurance than you really need. There are better things to do with your money than pay premiums that duplicate or overlap other insurance coverage.
- Keep your health insurance up to date. Some policies adjust for inflation better than others. But health care cost inflation continues, so make sure the benefits of your policies are not outdated. Review them annually.
- Do not drop one policy and buy another with similar benefits merely because the second one looks a little better or is a little less expensive. You could lose or delay benefits under a new policy because of waiting periods or preexisting condition limitations.
- Keep your health insurance policies in one place that is readily accessible and tell those people close to you where they are. Then make a list of the policy numbers and the companies that issue them in case the originals are lost or misplaced.
- Check for preexisting condition limitations that reduce or eliminate coverage of your current

health problems for certain periods of time. If you apply for coverage, be sure to answer all questions about your health truthfully and accurately to avoid having your policy cancelled later.

- Check your right to renew. Beware of policies that let the company refuse to renew your policy on an individual basis. These policies provide the least permanent coverage.
- Check with your state insurance department if you have any questions about the policy, the agent or the company he or she represents. The department cannot make a purchase decision for you, but it can tell you if the company you are dealing with is reputable and the policy meets state standards.
- Check for a "free look" provision. All companies give you 30 days to review the supplemental policy—it is required. If you decide you do not want it, send it back to the agent or company within the 30-day period and you will get a refund of all you have paid in premiums.

This is one of several free consumer booklets offered by the Health Insurance Association of America. Other subjects include:

Long-Term Care Insurance—*"The Consumer's Guide to Long-Term Care Insurance," C101.*

Health Insurance—*"The Consumer's Guide to Health Insurance," C103.*

Disability Insurance—*"The Consumer's Guide to Disability Insurance," C104.*

To order a copy, write to :

Health Insurance Association of America
P.O. Box 41455
Washington, D.C. 20018

Mr. ROYBAL. Thank you, Ms. Jenckes.

The committee will now go into the 5-minute rule. Each member will have 5 minutes for questioning. I am happy to, first of all, recognize the presence of Mr. Rinaldo, who is the Ranking Minority Member of the Aging committee and an active member of the Subcommittee on Health and Long-Term Care.

During those 5 minutes, he can ask or say anything that he wants, but I sincerely hope we can keep it to 5 minutes. Then we'll come back again for an additional 5 minutes and we'll take as many 5 minutes as we need to get the information that is required.

The Chair recognizes Mr. Rinaldo.

Mr. RINALDO. Thank you very much, Mr. Chairman.

I have an opening statement that I would request unanimous consent to put into the record in its entirety and perhaps I would take just a minute or two to highlight some of the key points.

Mr. ROYBAL. Without objection, that will be the order.

[The prepared statement of Mr. Rinaldo follows:]

OPENING REMARKS OF

REP. MATTHEW J. RINALDO

MR. CHAIRMAN,

I COMMEND YOU FOR CALLING THIS HEARING TODAY TO EXAMINE THE APPROVED AND PROPOSED PREMIUM INCREASES FOR MEDIGAP INSURANCE POLICIES. THIS ISSUE IS OF CRITICAL IMPORTANCE GIVEN THE RECENT VOTE BY THE HOUSE OF REPRESENTATIVES TO REPEAL THE MEDICARE CATASTROPHIC HEALTH CARE PROGRAM.

I THINK EVERYONE HERE WOULD AGREE THAT THE LAST THING WE ANTICIPATED WHEN WE PASSED THE MEDICARE CATASTROPHIC CARE PROGRAM WAS THAT INSURERS WOULD TAKE THIS AS A SIGNAL TO INCREASE PREMIUMS ON THEIR SUPPLEMENTAL POLICIES.

I AM DEEPLY CONCERNED ABOUT THE IMPACT SUCH INCREASES WILL HAVE ON OLDER AMERICANS LIVING ON FIXED INCOMES. ONE OF THE KEY REASONS SENIORS OPPOSED THE CATASTROPHIC PROGRAM WAS BECAUSE OF ITS COSTS.

NOW THE SAME INDIVIDUALS WHO ASKED US TO REPEAL THE PROGRAM COULD FACE SKYROCKETING PREMIUMS IF THEY CHOOSE TO REINSTATE THEIR SUPPLEMENTAL MEDIGAP POLICIES. THIS COULD PLACE THEM IN THE SAME FINANCIAL POSITION AS HAVING TO PAY THE SURTAX.

THOSE OF WHO VOTED TO REPEAL THE CATASTROPHIC CARE PROGRAM DID SO BECAUSE OUR CONSTITUENTS MADE IT CLEAR THEY WERE PAYING TWICE FOR THE SAME BENEFITS. THEY PREFER THE OPPORTUNITY TO SHOP AND COMPARE SUPPLEMENTAL POLICIES AND TO FIND THE ONE WHICH BEST SUITS THEIR NEEDS.

WE SHOULD NOT ALLOW THOSE WHO HAVE CHOSEN TO PROTECT THEMSELVES AGAINST MAJOR ILLNESSES TO BE TAKE ADVANTAGE OF IN THIS MANNER. SUCH ACTIONS ARE TANTAMOUNT TO PREYING ON THE ELDERLY.

ACCORDING TO AN ARTICLE IN THE NEW YORK TIMES ON OCTOBER 26, THE BLUE CROSS BLUE SHIELD ASSOCIATION ESTIMATES ITS MONTHLY PREMIUMS WILL INCREASE AN AVERAGE OF 43%, NOT INCLUDING INCREASE FOR HEALTH CARE INFLATION. I WAS ALSO PUZZLED BY THE COMMENT OF THE EXECUTIVE DIRECTOR OF GOVERNMENT RELATIONS FOR BLUE CROSS THAT ITS CINCINNATI AFFILIATE HAD PLANNED TO REQUEST A 1% INCREASE, BUT INSTEAD REQUESTED 22%.

I HOPE THAT WHEN CATASTROPHIC IS RESOLVED BY THE HOUSE AND SENATE REASONABLE INCREASES WOULD SUFFICE TO COVER THE RISKS ASSOCIATED WITH MEDIGAP INSURANCE POLICIES.

I WANT TO THANK THE REPRESENTATIVES FROM THE INSURANCE INDUSTRY WHO ARE HERE TODAY AND APPRECIATE THEIR TESTIMONY.

AGAIN, MR. CHAIRMAN I COMMEND YOU FOR HOLDING THIS HEARING, AND I YIELD BACK THE BALANCE OF MY TIME.

Mr. RINALDO. I would just like to say that I think everyone on this committee would agree that the last thing that we anticipated when we passed the Medicare catastrophic program would be that this would be a signal to some insurers to increase premiums in their supplemental premiums.

I am deeply concerned about the impact such increases will have on older Americans living on fixed incomes, people who can't afford those increases, and certainly who sent me a strong signal every weekend when I went home that they opposed the catastrophic care program specifically because of its costs.

Now the same individuals who asked us to repeal the program could face what I consider skyrocketing premiums if they choose to reinstate their supplemental Medigap policies. And quite frankly, this places them in the same position, or maybe a worse position, than if they had to pay the surtax.

What I don't understand—and I got here late because of some confusion in this schedule—this originally, as you know, was scheduled for 10:30 and I didn't hear all of the testimony, but Ms. Jenckes, perhaps, can help me out.

Let me start out by asking, what percent of the insurable population is covered by a Medicare policy?

Ms. JENCKES. About 71 percent of the population does have private insurance, another 10 percent Medicaid.

Mr. RINALDO. That's a pretty high percentage, wouldn't you say, 71 percent?

Now suppose Congress had done nothing. Suppose we never passed that Medicare catastrophic bill. Never even discussed it. The study came in from Dr. Bowen and it was just shelved. How much of an increase would there have been then?

Ms. JENCKES. I've got to venture a guess, Mr. Rinaldo, it would probably be somewhat in the same neighborhood. As for this year given that the Part A deductible is increasing. Again, I'd like to have some actuaries from individual companies be able to respond on that for the record.

About 71 percent of beneficiaries have private health insurance in addition to their Medicare benefits. If you exclude from the total count those Medicare beneficiaries who also have Medicaid eligibility, the 71 percent with private coverage rises to 78 percent. [1989 HIAA survey of Medicare beneficiaries]

While we cannot calculate an average figure, it can be said that whatever, in fact, an insurer's 1989 Medicare supplement premiums were, they would have increased an additional $60 to $80 had the first year of the Medicare Catastrophic Act not been in effect.

The benefits we cover are associated with the rising costs of the Medicare program. Health care costs overall are a problem not just for the Medicare program but for all private payers. In essence, what we're doing in the private sector is just paying for what Medicare doesn't. Even absent catastrophic, physician costs to the Medicare program are going up on a 16 percent a year compounded basis.

Our premium costs will have to reflect that charge on the part of physicians.

Mr. Rinaldo. What you stated near the conclusion of your testimony was that if there was total repeal there would be a 20 to 25 percent premium increase.

Ms. Jenckes. You have to recall that the original law, prior to catastrophic, did require, 3 hospital deductibles—one for each spell of illness. As I mentioned, one-quarter of the beneficiaries are hospitalized every year. So an individual conceivably could be subject to 3 deductibles in a given year, and that's why together with rising medical costs the higher increase if everything was repealed overall.

What the catastrophic law does this year is require cover only one deductible per beneficiary and unlimited hospital stays.

Mr. Rinaldo. If everything was repealed overall it would be 20 to 25 percent. But if everything is repealed overall, it puts us in the same position we were in before we ever passed the law, which then I would think logically follows that if we continued the way we were without this law the increase would be 20 to 25 percent this year.

Is that correct?

Ms. Jenckes. Since health care costs are rising overall and utilization is increasing, it is impossible to say.

Mr. Rinaldo. What would you project for the following year? Is it going to be 20 to 25 percent each year?

Ms. Jenckes. I cannot predict that. General health care costs are rising 12 to 13 percent every year, and again, physicians' costs have been 16 percent a year on a compounded basis over the last 3 to 4 years.

Mr. Rinaldo. What is the average cost of this insurance? The average policy, what does it cost, do you have that figure?

Ms. Jenckes. Last year the average policy was in the range of $400 to $600, $700, depending on how comprehensive the policy was. Many of the policies will offer what we call balance billing; in other words, paying the additional physician charges if the doctor does not participate in the Medicare program, and these will cost more.

A Medicare supplement covering only benefits required by the NAIC minimum standards could be purchased for as little as $225 in 1988 and $250 in 1989. Such coverage, for example, would not pay the Part A hospital deductible ($564 in 1989). Most policies purchased do cover the Part A deductible and provide other benefits beyond the minimum requirements—some even covering physician fees in excess of Medicare's allowable charge. Thus, in 1989, an HIAA survey of 500 Medicare beneficiaries found them paying a mean supplemental premium of $718 and a median premium of $640.

Mr. Rinaldo. I see a few of the other witnesses shaking their heads. Would anyone like to comment?

Mr. Firman. Yes. As I mentioned earlier, we keep track of Medigap policies being sold in Virginia, Maryland, District of Columbia. And in fact, the average range of policies is between $600 and $1200 and the average policy somewhere more around $900 a year. So I don't know where these $400 and $600 figures are coming from, but they certainly don't reflect the costs in this region of the country.

Mr. RINALDO. Anybody else like to comment?

What could Congress do to keep the costs of these policies down lower, in your opinion?

Ms. JENCKES. I think what we have to do is look at costs that really affect the Medicare program and everyone else, and underway as the part of reconciliation legislation are several recommendations that in fact the House Energy and Commerce Committee, on which you serve as well, made for some changes in the way physicians are reimbursed, and I think that will be a key step. We've already seen program savings because of the implementation of the DRG system, the diagnostic-related grouping system for hospitals. We feel some changes must be made on the physician's side of the house too, and then I do think costs could be lowered.

Mr. RINALDO. In a priority fashion—in order of priority—could you give us a listing of the factors that necessitate the change in premium levels?

I know you mentioned them but let's have them in priority order.

Ms. JENCKES. Number 1, you've got the direct costs associated with the fact that the Medicare deductible is going to be rising this year from $560 to $592. You've got the fact that Part B costs overall are increasing in the neighborhood of 16 percent.

We have heard again—as a trade association person I do not have finite details on this—but inflation could be 5 to 7 percent overall. Then, of course, you've got increased claims volume and the number of beneficiaries that will reach. Again, it depends on to whether catastrophic will stay the course—in other words, whether Part B cap will trigger in this year or not. Still, Part B costs will be rising.

Mr. RINALDO. Is the trend towards more and more people buying Medigap policies?

You mentioned a percentage of about 70. Is that on the upswing or has it leveled off?

Ms. JENCKES. I would say it's about the same. Since about 35 percent receive it as part of their retirement benefits they continued to receive private Part B supplemental benefits this year. That's why the "maintenance of effort" provision for employers was included in the law.

We have found, in fact, that very few beneficiaries who purchase their own policies did drop their policies because only the Part A or the hospital side of the benefit was going into effect. I think they realized how high the costs were with Part B, so most kept their policies.

Mr. RINALDO. Okay. I understand my time has expired.

Thank you very much, Ms. Jenckes.

Mr. ROYBAL. Thank you, Mr. Rinaldo.

I would like to take my 5 minutes at this particular time and analyze what I think is the case at the present.

I think we've heard 3 viewpoints. First of all, we were told about the problem and how senior citizens are even dropping insurance and that they are having a rough time financially.

Then we also heard that the increases are justified, and that they are justified primarily due to the cost of the physician and

then, second, justified because more services are being provided to the elderly and for other reasons.

We also heard the third viewpoint from Mr. Firman and Mr. Gilmore that these increases are not justified, that they are too high, and that some reasonableness should be applied in determining future increases.

Now, Mr. Firman, you heard what Ms. Jenckes has said about why Medigap premiums went up in 1989. Do you think that her explanation is accurate? It may be accurate from her viewpoint, but what is your viewpoint?

Mr. Firman. With all due respect, I think that the HIAA is running interference for the members of this trade association by trying to soften up the public and the Congress so that companies can raise their rates higher than they are justified.

The logic doesn't stand up. What I see here is that they don't have any solid reasons—it's kind of the weight of reasoning, we'll throw up enough data and statistics and hope that it adds up to a justifiable rate increase.

Let me give you one example. Ms. Jenckes just testified that Medicare Part A deductibles have increased from $540 to $560 and that justified a 2½ percent in premium. But then she also noted correctly that under the changes in Medicare people are now limited to exposure of one hospital deductible a year instead of three hospital deductibles a year under the current law. That convenient fact was omitted from the weight of reasoning: Yes, there's been an increase in deductibles but there's also been a decrease in exposure.

I think as you go through these things point by point, you start to see that each has at most a marginal impact on rising costs. And I think that adding it all up, it just doesn't equal anywhere near the rate increases that we're seeing.

Mr. Roybal. Now, Mr. Gilmore, you heard the same testimony. I would like to know what your experience has been. Now, in your expert opinion, would the so-called increases in costs actually justify an increase in premiums that in some States go as high as 130 percent?

Mr. Gilmore. No, I don't think it's justifiable at all. I don't think that any increases in health care, especially when most of these Medicare supplemental policies are basic 20 percent copayment for Part B policies will have all that much effect on the liability for these insurance companies.

However, the insurance industry is doing something which is, what I feel, extremely dangerous. They are starting to rate their policies by different areas of the country. In other words, someone in, say, Dade and Broward County in Florida, will pay a different premium for the same Medicare supplement as someone in perhaps Jacksonville or someone in Indiana. The reason why they're doing that is because health care costs are a little bit higher than in perhaps Dade and Broward County than they would be in Jacksonville or in Tampa. Yet, it's not a proper way of spreading the risk out for the entire senior population.

It also provides the insurance companies a way of stating, "well, we sell in the State of Florida," but they're pricing their product

out of the market in areas where health care costs a little bit more than in areas where it doesn't.

So, in other words, they don't really want to sell in what they call high risk areas. They only really want to sell in the areas where they are not going to have much liability to begin with.

So the whole idea of boosts of 25 percent and upwards is, in my opinion, unwarranted. It doesn't show up in claims, and it definitely doesn't show up in the claims that I've experienced from my clients over the last several years.

Mr. Roybal. It is also my understanding that there are instances in which the agent who sells the insurance gets as much as 75 percent on the first-year premium.

Mr. Gilmore. That's correct.

Mr. Roybal. Doesn't that add to the cost?

Mr. Gilmore. It sure does.

Mr. Roybal. Wouldn't that add to the costs more than the so-called more services that are being provided to the elderly?

I don't see where more services are being provided to the elderly, but let us assume that that is a fact, and slightly more services are being provided.

Overall, what would be the difference then in the cost if each agent—and this is just a hypothetical question—if each agent were to receive 75 percent of the first year's premium, wouldn't that increase the cost tremendously?

Mr. Gilmore. It's increased the cost throughout the history of Medicare supplemental insurance. What we are talking about now here is a big jump in premiums. Whereas, back in 1983, 1984, 1985, the sales commissions on Medicare supplements have been around 75 percent.

Under this, however, the 75 percent does not all go to the agent. It goes to the agent's manager and the marketing directors. In other words, 75 percent of the total premium would go. However, that is a very large chunk of a first-year premium to go just for the individual with the marketing team. In other words, it's money that the insurance company does not have to pay claims because they must pay their agents.

Mr. Roybal. Ms. Jenckes, my time is up but I'll come back, and when I do I want to ask you what you think of the situation. I want to know why is it that the cost of Medigap insurance is going up. Give me your assessment of what effect that portion of the premium, up to 75 percent, that is being collected by the agent, and other costs, may be adding to the increase in the insurance rates.

I'll come back to you later.

The Chair will now recognize Mr. Regula.

Mr. Regula. Thank you, Mr. Chairman.

I ask unanimous consent to make my statement a part of the record.

Mr. Roybal. Without objection, that will be the order.

[The prepared statement of Mr. Regula follows:]

OPENING STATEMENT OF THE HONORABLE RALPH REGULA, 16TH, OHIO
VICE-CHAIRMAN
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

November 2, 1989

Mr. Chairman:

I commend you for your decision to examine this important issue as the new chairman of our subcommittee. Much confusion and misunderstanding exists over the complicated subject of Medigap coverage and increased premiums.

Recently, the insurance industry indicated that premiums for Medigap coverage will rise in 1990. For example, Massachusetts Blue Cross-Blue Shield reportedly plans to ask state approval for a 75% increase in its premiums if the catastrophic law is totally repealed. From information provided to the subcommittee's minority staff this is an extreme example with most insurers asking for increases between 11% to 25% based on total repeal. But all experts agree that some increase is merited because of increased cost and utilization by seniors.

As you know, over 25 million of the 33 million Medicare recipients currently carry the additional insurance which is 78% of all beneficiaries. Premiums for these policies range from $200 to $1300 a year.

What is the cause of the proposed increases and are they appropriate? The repeal of catastrophic would have a significant effect upon premium amounts. AARP estimates benefits presently covered under catastrophic result in only small premium savings of $2.25 to $2.50 per month. Since only the extended hospital stays and skilled nursing facility care are

covered some would argue the industry is already paying the larger costs of the physician cap and cannot claim such expenses as a basis for increases.

However, the insurance industry traditionally determines premium levels in a cyclical manner. Usually every three years premiums are adjusted to reflect miscalculations in the prior level. Many insurers established current premiums based upon the original assumption of continuation of the catastrophic benefits. Therefore, current premiums would reflect expected savings in the out-years not yet achieved under the law. Under existing law, in 1990 Medigap policies will be required to cover a maximum of $1295. Without the Medicare expansion, Medigap policies will have a potential liability of $50,000.

Of course, other considerations are the continued rise in health care costs due to inflation and utilization trends. All these numbers reveal the increases in liability of private insurers absent the government program.

Those who support total repeal would say these figures are inflated and misleading. No doubt some insurers will attempt to use these changes in law to their advantage. It is the responsibility of the state insurance commissioners to address this issue while it is our duty to carefully consider the effect of federal law upon premiums.

I voted for repeal of the program. But any repeal must also be coupled with the maintenance of certain primary benefits. To do this lowers any

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expected premium increases by a comparable amount while the poor elderly can retain health coverage they would otherwise be unable to afford. If not, the 20 million elderly taxpayers with incomes below $15,000 who would have received the benefits without paying the surtax will simply not have access to care.

Congressmen Schulze, and myself, have introduced legislation to provide for a benefit package based on the McCain plan which passed the Senate by a vote of 99-0. We are confident this will go toward alleviating the potential costs to the poor elderly.

I look forward to the testimony of our distinguished witnesses on this complicated issue.

Mr. REGULA. I'd just like to ask a few questions.

Ms. Jenckes, on the bill that passed the Senate, the so-called McCain bill, what impact would that have on the rate increases? Would it moderate the increases as proposed in the event of a total cancellation of catastrophic?

Ms. JENCKES. Again, our best "guesstimate" would presume somewhere in the neighborhood of 15 to 20 percent. We don't have hard figures from our companies—but would like to suggest that since the GAO has in fact been talking to some of our individual companies as well as Blue Cross/Blue Shield, they may be able to provide you with additional information.

Mr. REGULA. Under the McCain package, 15 to 20, whereas, it will be 25 without that. That is, if there's a total repeal of catastrophic, without the McCain language?

Ms. JENCKES. Correct.

When I referred to total repeal of catastrophic, that means even eliminating Part A, which is in effect this year.

Mr. REGULA. Right.

I note that in the study prepared for the Budget Committee, the CBO projections on Medicare cost increases, for at least 1990, are 15.7, and yet, you show an increase, in the absence of catastrophic, of about 25.

How would you explain the disparity there?

Ms. JENCKES. Could have 3 deductibles on the hospital side as part of it.

And then again, just the volume of Part B claims and the fact that a lot of hospital services are being done on the outpatient basis.

In November, 1989, a GAO survey of 20 insurers found that anticipated rate increases due to repeal of the Medicare Catastrophic Coverage Act ranged from a low of 6.3 percent to a high of 41.3 percent, the average being 15.4 percent.

Our estimate of a 20 to 25 percent increase in 1990 if the Medicare Catastrophic Coverage Act were repealed, includes not only the cost effect of repeal, but other general factors such as claims experience and benefit utilization trends. The GAO estimate of 15.4 percent reflects only the effect of repeal, i.e., the transferring to private insurance of costs formerly covered by the government catastrophic benefit.

Mr. REGULA. Has there been an increase in the use of outpatient treatment? Statistically, is there evidence that that's a growing approach to delivering health care?

Ms. JENCKES. No doubt about it. I do not have any hard and fast statistics on that, but I'm sure the Health are Financing Administration could provide you with some immediate experience, at least in terms of the Medicare program.

Mr. REGULA. Do you attribute the growing cost to increased utilization or to increased fees and costs, or just more people, or—

Ms. JENCKES. Mr. Regula, it is really a combination of all of those factors together.

Mr. REGULA. Does the fact that the length of life is increasing, that the life expectancy is growing? Is that a factor, based on your evidence?

Ms. JENCKES. All of these factors would come into play.

Mr. REGULA. Did you have any incidence of cancellation of Medigap policies as a result of people anticipating catastrophic? Was there any evidence that they were cancelling because they assumed that catastrophic would take care of their problems?

Ms. JENCKES. Based on what we learned from our companies, most people did not drop their policies. In fact, since we were talking about a 3-year implementation period with hospital coverage expanded first people, indeed, were concerned that they still wanted at least the Part B or medical services to continue to be picked up at least until that portion of the law was phased in. Again, I think once the law was passed, there was a consumer concern being raised to Members of Congress as well as State legislators on what the effect of the law would be. Since Congress was already entertaining some changes, that too even persuaded some to stay with their policies.

Mr. REGULA. Do you have any percentage figure of those that did cancel?

Ms. JENCKES. I know that the majority did not drop their policies.

I'd also like to make another comment. We do have a survey that I'd like to submit for the record where 90 percent of the beneficiaries have said that they are extremely satisfied with their private policies. This survey was done this year as catastrophic was going into effect. They were pleased with the price, they were pleased with the delivery system, and felt that it really filled in a necessary gap.

When you are at this age, 65 and over, your health is everything. We feel that we have offered a substantial amount of protection and security to a lot of Americans.

[The survey follows:]

HIAA

RESEARCH BULLETIN

Older Americans and Their Health Coverage

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October 1989

Executive Summary

This Research Bulletin reports findings from a national telephone survey of 500 elderly Americans conducted in April and May 1989. The elderly responded to a host of questions including: (1) knowledge of the catastrophic legislation; (2) concerns about remaining gaps in Medicare coverage; (3) satisfaction with changes in Medicare brought about by the recent legislation; (4) private health coverage and satisfaction with it; and (5) plans for dropping private coverage.

Survey results indicate that despite the extensive publicity, the elderly still know very little about the basic aspects of the catastrophic legislation. The average percentage of correct answers for nine questions on recent changes was only 28 percent.

The elderly are very worried about incurring any out-of-pocket costs and strongly desire complete coverage with no coinsurance or deductibles. For example, 66 percent are "very concerned" about having to pay for the first $600 of prescription drug costs not covered by Medicare.

Medicare beneficiaries are substantially less satisfied with the cost and benefits of the Medicare program today than they were prior to the catastrophic legislation. More than 70 percent expressed satisfaction with the cost of the Medicare program before the legislation, but only 30 percent are satisfied after the legislation.

More than 78 percent of the older people in the sample had private insurance coverage to supplement their Medicare coverage. (Individuals with dual Medicaid-Medicare coverage were excluded from the sample.) Nearly 90 percent of owners report satisfaction with benefits, while 75 percent were satisfied with their cost of private coverage. Despite the recent catastrophic legislation, 83 percent of the elderly plan to renew their policies, 2 percent plan to drop them and the remaining 15 percent "don't know." The "informed" segment of the sample were equally likely to renew their policies as those who were not briefed about changes in Medicare benefits. Fear of any remaining costs not covered by Medicare is a major reason why the elderly plan to retain their private coverage. Hence, insurance companies that provide dependable coverage against these expenses will continue to attract the older population.

Older Americans and Their Health Coverage

In 1988, Congress made substantial changes in the Medicare program — the first major changes in the benefit and financing packages that beneficiaries have seen in the nearly 25 years since the program was enacted. Rather than rejoicing over improved benefits, however, there has been a great deal of public opposition to the Medicare Catastrophic Coverage Act among the elderly. Complaints center largely on its financing methods, but also on what some people consider to be its shortcomings in protecting older Americans from catastrophic health care expenses.

There are now a number of proposals before Congress to revamp the legislation. These include making the additional benefits and payments (monthly premiums and additional income taxes) voluntary, lowering the maximum income tax liabilities, spreading the cost of program benefits beyond the elderly and even repealing the new benefits. It is difficult for Congress to act, however, since it is unclear whether the public opposition is that of a vocal (and relatively wealthy) minority or, alternatively, is broad-based. (As this *Research Bulletin* goes to press, Congress is poised to enact changes in the Medicare Catastrophic Coverage Act with any resulting legislation holding broad implications for this study.)

Beyond the issue of the legislation's popularity, another issue of concern is what spillover effects, if any, will be felt in the private insurance market. More than 70 percent of Medicare beneficiaries own private health insurance to supplement Medicare,[1] an estimated $13 billion market in 1986.[2] A question raised by the legislation is whether beneficiaries will now drop their private health insurance coverage because they believe Medicare's new benefits will provide sufficient protection.

◆ The Medicare Catastrophic Coverage Act

The Medicare Catastrophic Coverage Act makes a number of changes in both program benefits and financing that will be phased in over the next several years. The three most important new benefits involve hospital care, Part B expenses (primarily physician care) and prescription drugs. Beginning in 1989, beneficiaries are no longer responsible for substantial daily copayments for hospital stays exceeding 60 days. Furthermore, they pay a $560 hospitalization deductible only once in a single calendar year. Starting in 1990, there will be a $1,370 annual cap placed on Part B copayments. Prescription drug coverage — an entirely new Medicare benefit — will be phased in between 1990 and 1993; ultimately,

Medicare will pay 80 percent of drug costs after an annual deductible of approximately $600 is met.

There are other benefit enhancements as well, most notably liberalization of Medicaid regulations that allow the spouse of a nursing home resident to retain enough income to avoid impoverishment. Although there were some modest changes in the Medicare nursing home benefit, one of the primary complaints about the legislation is that it does not extend Medicare coverage to long-term nursing home care. This type of care is most likely to impoverish the elderly.[3]

Unlike prior Medicare benefits, the new ones are to be financed entirely by program beneficiaries. Most of the cost will be funded through the controversial supplemental premium, which is actually an additional amount of income tax to be paid by an estimated 40 percent of the elderly. The maximum tax liability, which will be paid by less than 10 percent of the elderly, is scheduled to be $800 per person ($1,600 for a couple). In addition to the supplemental premium, the Part B monthly premium charged to all program beneficiaries whose incomes are above the poverty level will increase by $4.

After the benefits are fully phased in, the following expenses will still be borne by beneficiaries (or by their private insurance policies): the initial $560 hospital deductible for Part A; the $75 Part B deductible and 20 percent coinsurance payment until annual expenses of $1,370 are incurred; all nonassigned physician charges above what Medicare deems to be reasonable; the first $600 of prescription drug costs; and 20 percent of all additional prescription drug costs during a year.

◆ Survey Methodology

Survey results are from a telephone survey of 500 Medicare beneficiaries which was conducted in April and May of 1989 to determine their level of understanding about and satisfaction with Medicare and private supplemental insurance. The survey, carried out by Response Analysis, Inc., of Princeton, New Jersey, was based on a nationally representative sample chosen using random-digit dialing.

Because only those households with at least one person age 65 or more and on Medicare were accepted into the sample, only a small fraction of households contracted were eligible. Individuals who were dually eligible for Medicare and Medicaid were not interviewed because they normally do not purchase private health insurance to supplement Medicare.

Response Analysis was able to screen eligibility information for 71 percent of the telephone numbers of residential households with working telephones. The majority of the remaining 29 percent hung up before or during the screening interview. Of the eligible households, 85 percent did not have anyone age 65 or older, and a few others were excluded because the elderly residents were not eligible for Medicare or were dually eligible for Medicare and Medicaid. Of the households that met all of our eligibility standards, 68 percent completed the interview. On average, there were six calls necessary per completed interview; the interviews themselves lasted an average of 19 minutes. To ensure the representativeness of the sample, when there was more than one person age 65 or older in the household, the person with the next birthday was chosen for the interview.

Of the 500 completed interviews, 391 (78 percent) owned private insurance to supplement Medicare and 109 did not. We employed a split-sample technique to assess the impact of respondents' level of understanding of the recent changes in Medicare. Interviewers briefed half of the private insurance owners on the details of the new legislation's benefits, but did not brief the other half. Instead, interviewers quizzed them to determine their level of understanding. Nonowners also took the quiz.

Interviewers asked elderly respondents whether they were or someone else was more familiar with their private health insurance policies. If someone else was said to be more familiar, the interviewers tried to contact that person to find out the desired information about health insurance coverage, including whether the original respondent was likely to drop his or her health insurance policy in the wake of the Medicare Catastrophic Coverage Act. Curiously, only 14 of the 391 policy owners said that someone else was more familiar with their insurance. In these 14 cases, we used the information from the original elderly respondent to construct all variables except those concerning their experience and satisfaction with private health insurance. We suspect that the reason that so few people claimed that someone else was primarily responsible for insurance decisions was that the question was asked well after the interview had begun, and respondents were reluctant to admit that they were not the best person to speak with or did not want to bother other household members.

Table 1 shows some of the characteristics of the sample, in comparison with national figures published in the *Statistical Abstract of the United States.*[4] Although the survey sample differs somewhat from the national

Table 1 The Sample Compared to the Elderly Population as a Whole

Demographic Characteristic	HIAA Sample	National Sample*
Age		
65-74	65.2%	59.3%
75 and over	34.8	40.7
Sex		
Male	33.6	40.6
Female	66.4	59.4
Race		
Black	5.8	8.4
Hispanic	0.4	3.0
Caucasian	93.8	88.6
Marital Status		
Married	47.9	55.7
Unmarried	52.1	44.3
Education		
0-11 Years	38.2	48.8
High School Graduate	32.1	30.8
Some College	29.7	20.3
Employment Status		
Employed	7.7	10.7
Not Employed	92.3	89.3

*Source: *Statistical Abstract of the United States*, 1989 (see note 4)

figures, no clear pattern emerges. Compared with the national figures, survey respondents were more likely to be (or claim to be) somewhat younger, female, white, unmarried, better educated and not employed. Some of the differences probably can be explained by the nature of the survey. For example, blacks may have been underrepresented because individuals who were eligible for both Medicare and Medicaid (the poorest of the elderly) were excluded from the sample since they have little need for supplemental health insurance. Hispanics may have been underrepresented for the same reason and because of language problems over the telephone. Furthermore, both groups could have been underrepresented because they are less likely to have telephones. On the other hand, younger Medicare beneficiaries might be over-represented because they are more likely to live in private residences.

Other differences, however, are more perplexing. For example, it is odd that the survey sample exhibits traits indicating both higher economic

status (e.g., more education) and lower economic status (e.g., female, unmarried). One possible explanation is that respondents were less truthful about some personal characteristics (particularly education) to Response Analysis interviewers than they may be to national census takers. The reason that the survey may have overrepresented females (and therefore probably the unmarried as well) may have been that females were more likely to answer the phone and were more willing to be interviewed. Although an attempt at randomization was made by asking to interview the elderly person with the next birthday if there were two over age 65 in the household, it is possible that in some cases this request was not followed by respondents. Finally, since this sample was the result of a random selection process, some difference ffrom census figures is to be expected.

◆ The Elderly's Knowledge of Medicare Changes

One purpose of the survey was to determine the degree to which the older Americans understand the recent changes in Medicare. On one hand, their knowledge levels might be high given the extensive amount of press coverage concerning the changes. On the other hand, previous research has shown that the elderly appear to understand few of the specifics of their Medicare coverage.[5]

To assess knowledge, we asked nine questions about the recent changes in Medicare to 303 individuals: the half of the split sample of owners to whom we did not explain recent changes (N=194), and those who did not own private insurance policies (N=109). For each item, interviewers asked respondents to indicate whether the statement was correct, incorrect or that he or she did not know. The "don't know" choice was included to reduce the amount of guessing, and therefore better gauge true knowledge levels.

The nine questions (with answers in brackets) represented six primary aspects of the legislation:

- ***Hospital Coverage***
- With the new catastrophic coverage, Medicare will cover all costs of a hospital stay, except for an initial payment of about $500 [True].
- ***Physician Coverage***
- Medicare will cover all costs that your physician charges you for services [False].
- Medicare will cover all reasonable costs of physician services after the first $1,400 or so per year is paid [True].

- ***Nursing Home Coverage***
- Medicare will cover most of the costs associated with a six-month nursing home stay [False].
- ***Prescription Drug Coverage***
- When the new legislation is fully phased in, Medicare will cover some of the costs associated with prescription drugs [True].
- Medicare will pay 80 percent of all reasonable prescription drug costs during a year [False].
- ***Spousal Impoverishment***
- Medicare will provide some protection to the husband or wife of a nursing home patient to avoid loss of all of his or her assets in paying for nursing home care [True].
- ***Financing***
- All people who have Medicare will be required to contribute toward the cost of the new Medicare benefits through an increase in the monthly premium [True].
- All people who have Medicare will be required to contribute toward the cost of the new Medicare benefits through an increase in their federal tax payments [False].

Some issues are not as cut-and-dried as the questions indicate. For example, only those above the federal poverty level are required to contribute $4 a month in additional premiums; we did not believe that this nuance would affect our results, particularly because people who received Medicaid benefits were excluded from the survey. Another example concerns the nursing home benefit. Although the new legislation could, in theory, provide coverage for up to five months, the press has made it clear that the vast majority of nursing home stays still will not qualify for Medicare coverage. Finally, it is actually Medicaid rather than Medicare that provides spousal impoverishment protection under the catastrophic legislation; however, it might have been extremely confusing to explain both the Medicare and Medicaid programs in the survey process.

Table 2 shows the percentage of sample members who responded correctly to each question. Most noteworthy is that there is very little knowledge about Medicare changes. For the nine questions, the average percentage of correct answers was only 28 percent. Knowledge levels varied a great deal, however, from question to question. For example, 47

Table 2 Respondents Correctly Answering Selected Questions

Item	Percent of Correct Responses
Covers all hospital costs except deductible	34.1%
Doesn't cover all physician charges	46.5
Covers all reasonable charges after $1,400	15.5
Doesn't cover most costs of six month nursing home stay	19.1
Covers some prescription drug costs	38.6
Doesn't cover 80% of all prescription drug costs	23.5
Provides spousal impoverishment protection	18.5
All must pay monthly premium	48.5
All do not have to pay additional income taxes	8.9

percent knew that Medicare did not cover all physician charges, but only an extremely low number (9 percent) was aware that not everyone must pay more in federal taxes to finance the program.

Other findings were just as surprising. For example, despite lengthy congressional debate on Medicare's lack of coverage for long-term nursing home care, only 19 percent of respondents knew that Medicare would not cover most of the costs of a six-month nursing home stay. Many observers would claim that the centerpiece of the new legislation is added prescription drug coverage, yet only 39 percent knew that Medicare would include any such benefits.

We conducted t-tests and one-way analyses of variance (that is, statistical tests to examine whether the difference between two or more groups of people is greater than the normal variation of numbers) to determine if knowledge levels varied along a number of characteristics. We found (with significance levels in parentheses) that those with the highest scores were younger (10 percent), married (1 percent), Caucasian (1 percent), better-educated (1 percent) and wealthier beneficiaries (1 percent). Not surprisingly, education was a particularly important determinant of knowledge. For example, beneficiaries who had attended at least some college correctly answered an average of 3.5 questions, compared to only 1.7 for those who did not finish high school. Nevertheless, the best educated of the elderly correctly answered only about one-third of the questions, underscoring how poor Medicare knowledge really is.

The elderly have formulated opinions about the Medical Catastrophic Care Act; unfortunately, these opinions appear to be based more on ignorance than facts. Given that this piece of legislation has received an unprecedented amount of press coverage — beginning with the Bowen Commission study a year before passage of the legislation and continuing to this day — it is indeed perplexing how little of this information has been assimilated.

◆ Concern about the Remaining Gaps in Medicare

We asked respondents six questions regarding their concern about some of the gaps that remain in Medicare even after passage of the Medicare Catastrophic Care Act. These questions were asked of all 500 respondents. (Owners of private policies were asked what their level of concern would be if they did not have any insurance to supplement Medicare.) Respondents were given four choices: "very concerned," "somewhat concerned," "not too concerned" and "not at all concerned." The specific expenses addressed were:

- The first $560 of a hospital stay;
- The $1,400 (approximate) in Part B payments;
- Doctor bills higher than the Medicare allowed amount;
- The first $600 in prescription drug costs;
- Paying for a long nursing home stay; and
- Paying for dental care.

Figure 1 shows the proportion of respondents who were either very concerned or somewhat concerned about these expenses. The message that emerges is that the elderly are very worried about incurring any out-of-pocket costs. Stated differently, it appears that they strongly desire complete insurance coverage (i.e., with no deductibles or coinsurance), which probably explains why so few plan to drop their private insurance coverage in the wake of the Medicare changes.

Fully 78 percent said they were "very concerned" about long nursing home stays and 71 percent felt "very concerned" about excessive physician charges. Both of these expenses are unknowns and have the potential of causing great financial hardship. It is interesting that respondents also are concerned about fixed expenses that by most standards are not terribly high, especially when compared to supplemental health insurance premiums. (As discussed later, our respondents reported paying mean annual premiums of $718.) For example, 66 percent were

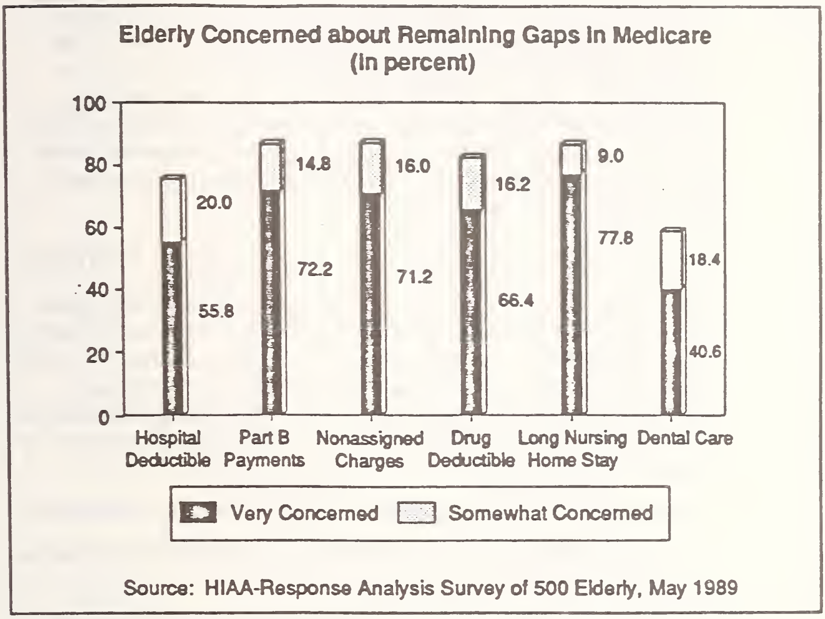


Figure 1

very concerned about the first $600 of prescription drug costs and 56 percent were very concerned about the Part A hospital deductible.

We do not mean to imply that the elderly are mistaken in their concern — obviously, it is a subjective assessment. Rather, the picture that emerges from the findings is a group of people with a weak understanding of the Medicare program, and who appear to deal with the resulting uncertainty by desiring coverage for any remaining gaps. Concern over lingering gaps in Medicare may prompt many to retain their private supplemental insurance, an issue addressed later.

We conducted chi-square tests (that is, statistical significance tests that show whether there is a relationship in a categorical variable between two or more groups) to examine variables associated with the level of concern. The most consistent finding was that people with lower incomes tended to be more concerned about all of the remaining gaps in Medicare. For example, whereas 73 percent of those with annual incomes below $10,000 said they were "very concerned" about the $560 Part A deductible, this was true of only about 36 percent of those with incomes above $20,000. Two other consistent findings across the six

"concern" questions were that younger beneficiaries were more concerned than their older counterparts, particularly with regard to long nursing home stays and that the less educated were more concerned about Medicare's gaps. We have no ready explanation as to why younger beneficiaries expressed a greater degree of concern than their older counterparts. Another curious finding was that whites expressed more fear than nonwhites about the costs of long nursing home stays, but less concern about dental costs.

◆ Attitudes about Medicare and Medicare Changes

The survey measured respondents' satisfaction with Medicare benefits and costs both before and after the recent changes. Here the split-sample technique becomes important. We are particularly interested in whether those to whom we explained the changes in Medicare's benefits responded more positively than those in the control group, who did not receive an explanation of the new benefits. The results are from the 78 percent of respondents who own private insurance.

There were five questions concerning their satisfaction with Medicare:

- How satisfied they were with Medicare's benefits before the legislation was enacted;
- How satisfied they are with program benefits after the legislative changes;
- How satisfied they were with Medicare premium costs before the changes;
- How satisfied they are with Medicare premium costs and any additional income taxes they may have to pay; and
- Their overall opinion of the new legislation.

For each of the first four questions, respondents were given four choices: "very satisfied," "somewhat satisfied," "not too satisfied" and "not at all satisfied." The first two categories fit into an overall "satisfied" category and we eliminated "don't know" responses so that the resulting percentages indicate the level of satisfaction among those with an opinion.

Figure 2 shows satisfaction levels with Medicare benefits before and after the legislation passed. An unexpected finding was that among both those to whom new benefits were explained and those to whom they were not, respondents indicated more satisfaction with Medicare benefits before these benefits were expanded. In both groups, approval levels declined by more than 10 percentage points. The findings with

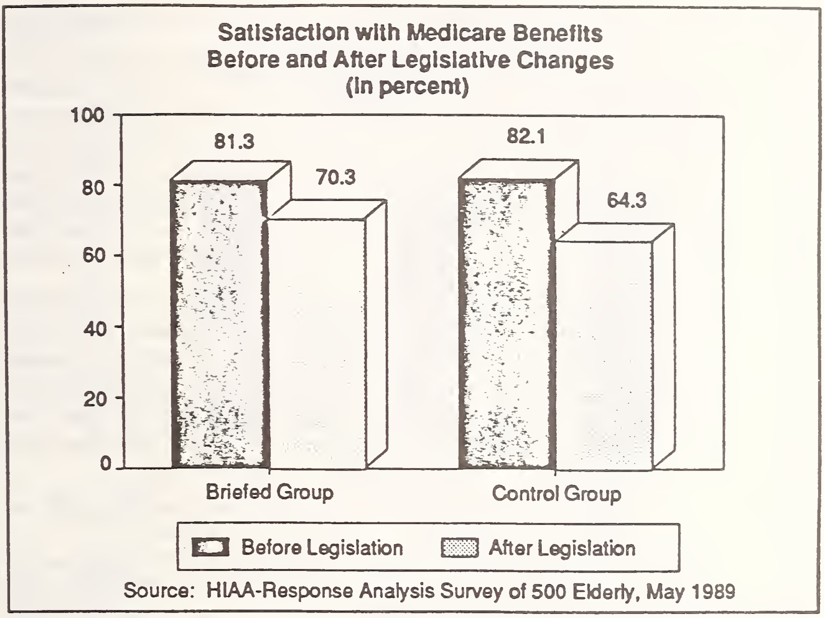


Figure 2

regard to costs are shown in Figure 3. Whereas more than 70 percent of respondents were satisfied with their payments before the legislation, satisfaction fell precipitously to around 30 percent afterwards. Furthermore, similar levels of dissatisfaction were recorded among different income levels. We believe that this strong dissatisfaction with the financing mechanism of the new law has colored the elderly's view of the benefits. This in turn might explain the anomalous result that they preferred the old, more limited Medicare benefit package.

We conducted chi-square tests to determine characteristics associated with Medicare satisfaction levels (both benefits and costs) both before and after the new legislation passed. The only statistically significant pattern was that those in fair or poor health were less unsatisfied with program costs after the new legislation (significant at the 10 percent level).

Whether most elderly people approve overall of the recent changes is an important question. To address this, we asked respondents:

> Taking into account both the benefits and costs [of the Medicare Catastrophic Care Act] to you, which of the following describes your opinion about the changes in Medicare?

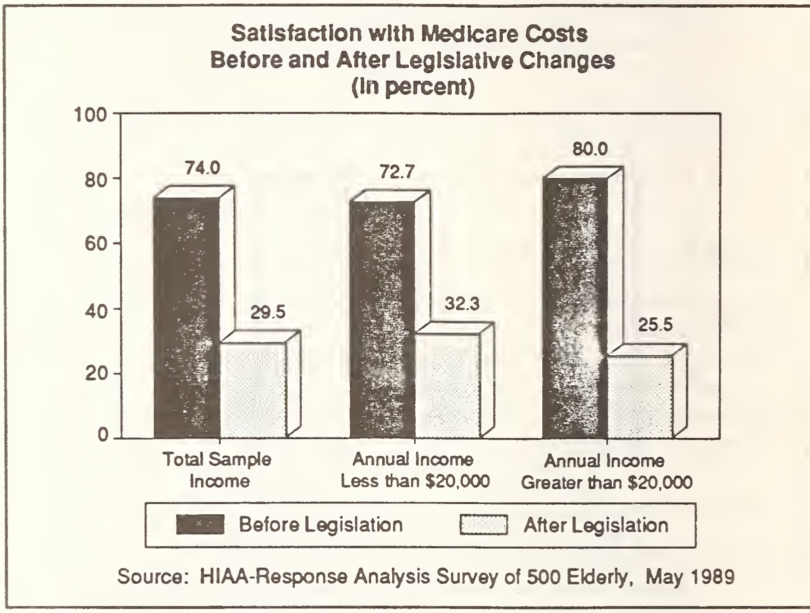


Figure 3

> Do you (1) strongly support the changes, (2) support the changes somewhat, (3) oppose the changes somewhat or (4) strongly oppose the changes?

Table 3 presents the results for all respondents and for each of three groups: the owners of private insurance to whom benefits were explained, the control group of owners who were not given an explana-

Table 3 Overall Opinion about the Medicare Catastrophic Coverage Act

	Briefed Owners	Control-Group Owners	Nonowners	Total
Strongly Support	9.2%	6.7%	5.5%	7.4%
Somewhat Support	24.5	27.8	24.8	25.9
Somewhat Oppose	21.9	17.5	11.9	18.0
Strongly Oppose	25.0	25.8	18.3	23.9
Don't Know	19.4	22.2	39.4	24.9

tion and nonowners. Looking first at the overall results in the last column, most of those who gave an opinion opposed the legislation. Whereas 33 percent of respondents strongly or somewhat supported the changes, 42 percent strongly or somewhat opposed the changes. Furthermore, opponents were more fervent: whereas 7 percent were strongly supportive, 24 percent are strongly opposed the changes. About one-fourth of respondents did not give an opinion. Chi-square tests of significance found no significant variables associated with respondents' overall opinions of the legislation.

No clear pattern emerges from the split sample. When people are given information about the changes in Medicare's benefits, they do not appear to be more in favor of the legislation than do members of a control group. In and of itself, this implies that public support may not grow very much as people become more familiar with changes in the Medicare law.

◆ Who Owns Supplemental Insurance Policies

Figure 4 shows the percentage of sample members who own policies, as well as those who own more than one policy. Since individuals who are jointly eligible for Medicare and Medicaid are excluded from the survey (they typically do not buy private coverage) ownership rates are higher. We found that 78 percent of those surveyed own Medicare supplemental policies, a figure identical to estimates made by the Congressional Budget Office.[6]

Approximately 85 percent of owners said they owned one supplemental policy, with the remaining 15 percent claiming to own two or more. Only 10 sample members (2.6 percent of owners) reported owning three or more policies; one sample member claimed to own as many as six.

There have been a number of previous studies on the characteristics of policy owners and nonowners.[7] Our results are consistent with most of these other studies. We performed chi-square tests and found that the following groups were most likely to own one or more policies (significance level in parentheses): individuals age 80 and under (10 percent), whites (1 percent), married (5 percent), better educated (1 percent), higher incomes (1 percent) and those reporting better health status (10 percent). Although most of the differences were not terribly great, race was a notable exception. Whereas 82 percent of whites owned policies, only 33 percent of nonwhites did. Although those with higher incomes were more likely to own private policies, there was no relation-

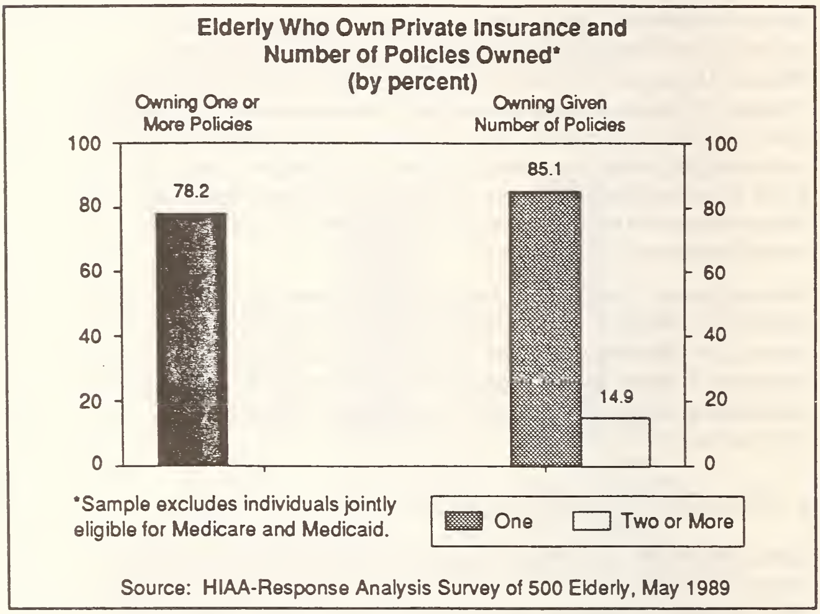


Figure 4

ship between ownership and income for income levels beyond $10,000. These patterns with regard to both race and income are consistent with previous studies on the determinants of policy ownership.[8]

We also conducted chi-square tests to determine what factors were associated with owning multiple policies. The only demographic or health status measures that were statistically significant (level of significance in parentheses) were that those with higher incomes were more likely to own multiple policies (5 percent) and those who had visited the doctor more in the previous year were more likely to own more than one policy (10 percent). This latter finding may simply indicate a utilization response. People who purchase more than one policy may demand more physician visits.

The mean and median annual premiums for private supplemental insurance policies reported by respondents is shown in Figure 5. The mean was $718 and the median, $640.[9] The Congressional Budget Office estimated that the typical premium for a Medicare supplemental policy was $542 in 1987.[10] Higher figures reflect the much-publicized fact that policy premiums have risen substantially since that time.[11] We con-

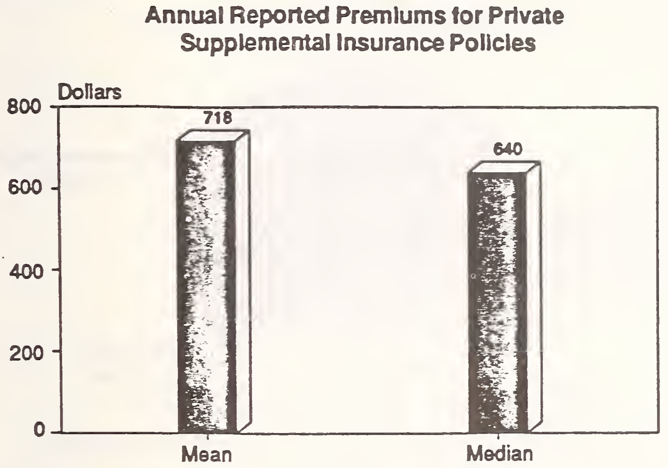


Figure 5

ducted t-tests on a number of individual characteristics that might be associated with higher premiums, but could find no variable that was statistically significant even at the 10 percent level.

We also asked respondents whether their premiums had increased during the previous 12 months. While respondent recall might be unreliable, particularly if the premium were being paid by an employer or former employer, we wanted to determine whether satisfaction with private policies is affected by premium increases (an issue examined later in the findings). Figure 6 shows that 47 percent of respondents indicated that their premiums increased, but 40 percent said that there was no change or that they actually decreased. Of those reporting an increase, the median was about 20 percent, or $12 a month.

Respondents were asked to indicate which of the following statements best described the policy(ies) they own (if they owned more than one policy, questions applied to the one with the highest premium):

- It pays many of the medical expenses not covered by Medicare; these are sometimes called "Medigap" or "Medicare supplement" policies;

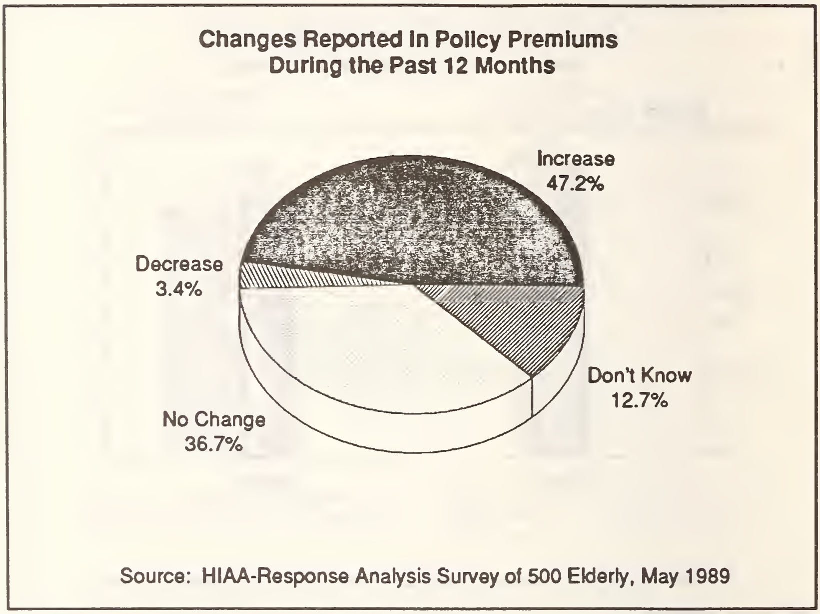


Figure 6

- It pays you a fixed amount of money for each day you spend in the hospital (hospital indemnity);
- It pays only for long-term care in a nursing home or care at home; or
- It pays only if you have a specific disease such as cancer.

Figure 7 shows the responses. The large majority of policy owners (90 percent) reported having Medicare supplemental policies. The next highest (8 percent), was for hospital indemnity, while only 1 percent each reported having specified disease or long-term care policies. It is possible that the non-Medicare supplemental policies were under-reported because, among those people who owned more than one policy, these policies were not their primary policy.

We asked those respondents who did not obtain their policies through an employer or former employer how they purchased their policies. The choices were: (1) through a group or association; (2) from an insurance company or agent; (3) through the mail, or (4) through an HMO. Figure 8 shows that 90 percent purchased policies through an association or group, or through an insurance company or agent of such a company.

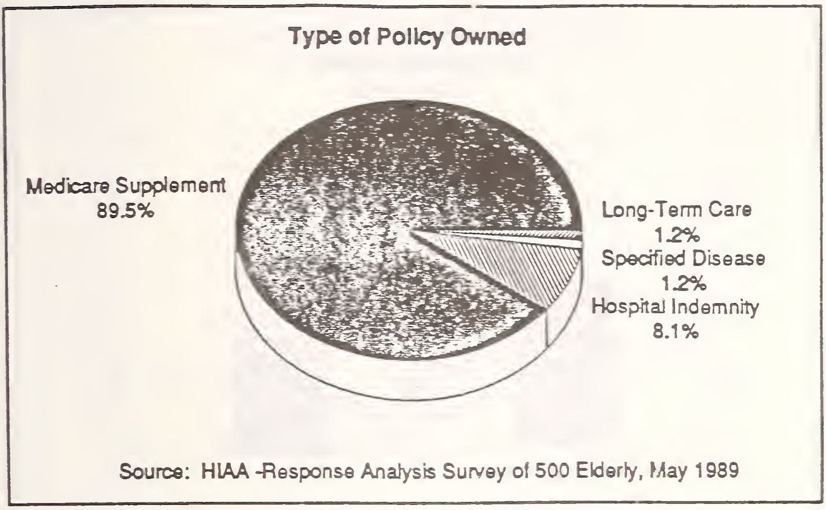


Figure 7

We also asked all respondents their desired method of purchasing a policy if they were doing it again. Not surprisingly, those who acquired their policies through an association or group preferred that method,

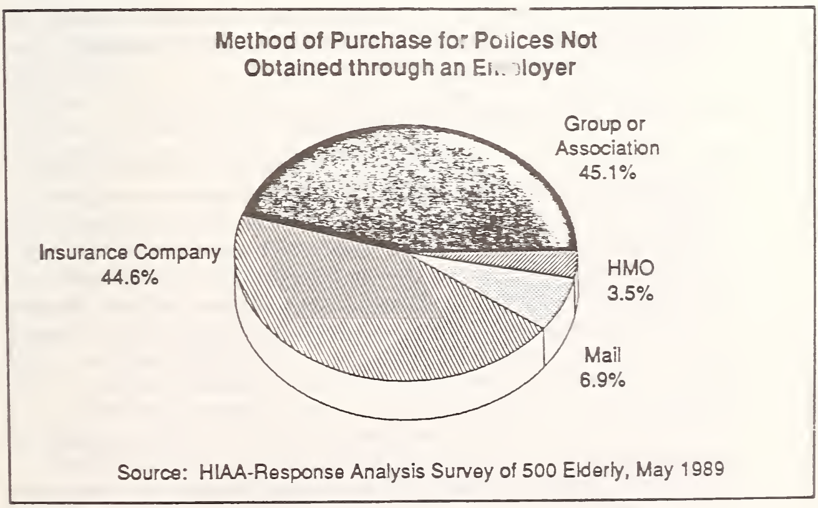


Figure 8

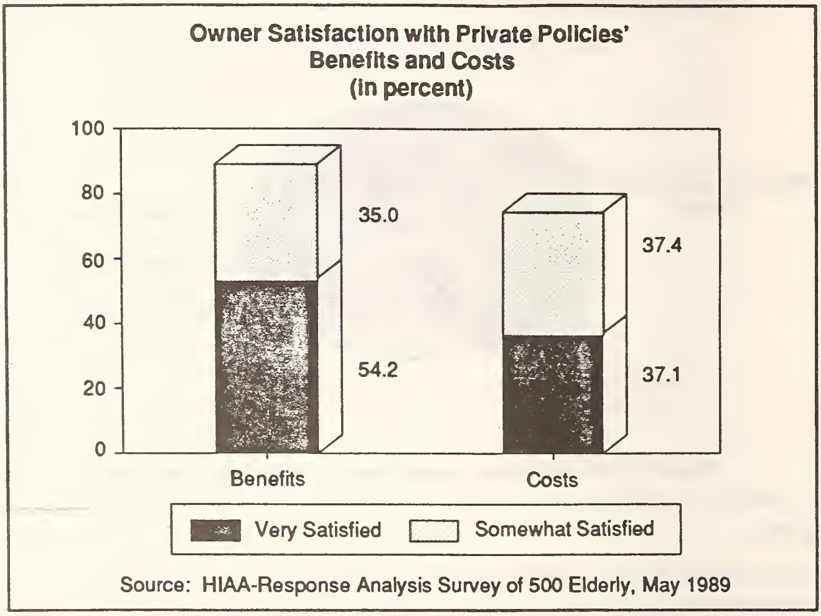


Figure 9

whereas those who used an insurance company thought that was best. People who acquired their policies through an employer or former employer overwhelmingly preferred that method.

◆ Satisfaction with Private Insurance Policies

We asked policy owners several questions about their satisfaction with their private insurance policies. The first two questions concerned satisfaction with policy benefits and costs. Respondents were given four choices: "very satisfied," "somewhat satisfied," "not too satisfied" and "not at all satisfied." (Respondents who answered "don't know" have been excluded from these tabulations.) Figure 9 shows that nearly 90 percent of owners report satisfaction with policy benefits and almost three-quarters with policy costs. These figures are a little higher than the Medicare satisfaction levels before the new legislation reported in Figures 2 and 3, and much higher than current Medicare satisfaction levels. Satisfaction with costs could be associated with whether the person said his or her premiums increased during the previous 12 months. People whose policy premiums had not increased were twice as likely to be "very satisfied" with policy costs (significant at the 1 percent level).

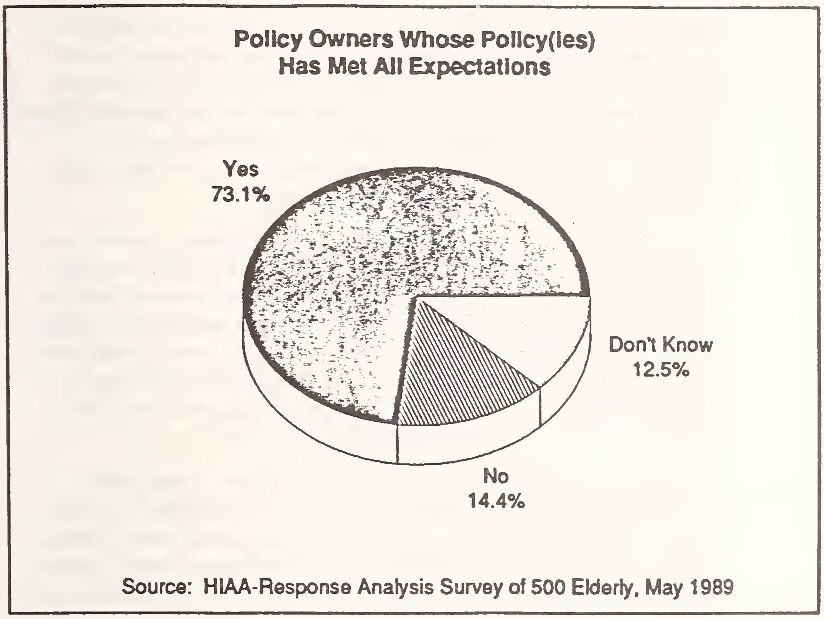


Figure 10

We conducted chi-square tests to determine characteristics associated with policy satisfaction, and found (with level of significance in parentheses) that high school graduates were more satisfied with both the benefits (1 percent) and costs (1 percent) of their policies. Those who said they were in only fair or poor health were less satisfied both with policy benefits (1 percent) and costs (5 percent).

Another question on the survey asked whether the respondent's private insurance policy "met all your expectations." Figure 10 shows that, for a large majority of owners, their policies did so. Almost three-fourths said that their policies met all expectations, while only 14 percent said that they did not. (The remaining 13 percent did not know, possibly because they had not yet used any policy benefits.) The most frequently noted shortcoming was physician care, followed by hospital, prescription drugs and dental services.

◆ Effects on the Private Market

One of the great unknowns about the new Medicare coverage is how it will affect the private insurance market. The legislation does remove

some of the reasons that elderly persons might have for purchasing supplemental coverage. In particular, two glaring gaps in Medicare were filled by the legislation. Beneficiaries are no longer at financial risk for hospital stays that exceed 60 days and there is now a cap on their 20 percent Part B coinsurance liability. The Medicare prescription drug coverage, when fully implemented, also removes some of the risks of incurring very high levels of out-of-pocket costs.

On the other hand, the legislation falls short of covering all health care costs. There are, of course, the remaining beneficiary financial responsibilities for hospital care ($560), Part B ($1,370 plus charges above the Medicare allowed amount for nonassigned claims), prescription drugs ($600 plus 20 percent of additional costs), as well as most nursing home care. Whether these remaining gaps would be sufficient to cause the elderly to retain their supplemental insurance policies was one of the most important research questions addressed in the survey.

As before, we employed the split-sample technique, to determine if there were differences among those who were briefed about the new Medicare benefits versus those who did not receive additional information. One could argue that the former group's responses might be more predictive of the long-run response, because over time it is likely that the elderly will gain additional knowledge.

Respondents were asked one of two questions, depending on whether they said they owned one policy or more than one policy. If a respondent owned one, we asked:

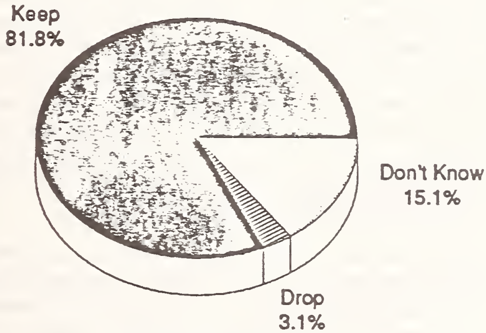
> What do you think you are likely to do once the new Medicare benefits are fully implemented? Do you plan to keep the additional health insurance policy that supplements Medicare or do you plan to drop it?

If a respondent owned more than one policy, the wording was:

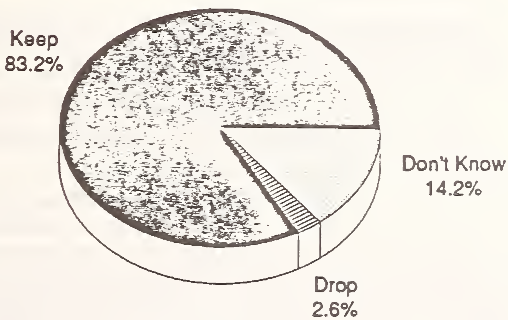
> Do you plan to keep all of the additional health insurance policies you have that supplement Medicare, drop some of them or drop all of them?

We have combined answers to these questions into three categories: keep all policies; drop one or more policies; or don't know. Figure 11 shows the response for the two groups, which are nearly identical. More than 80 percent in both groups reported plans to keep private insurance policies. Only 3 percent of each group had plans to drop one or more policies and about 15 percent did not know what they would do.

Private Insurance Owners Who Plan to Keep or Drop Their Policies



Briefed Group



Control Group

Source: HIAA-Response Analysis Survey of 500 Elderly, May 1989

Figure 11

Because insurers are particularly interested in the types of policyholders who plan to drop their supplemental insurance coverage, we performed a logistical regression analysis to examine the determinants of the decision. Logistical analysis is a technique that allows one simultaneously to examine predictors of a yes-or-no variable, such as whether a person plans to keep or drop an insurance policy. Few respondents said they planned to drop their policies. Therefore, we defined the dependent variable as equal to 1 (or "yes") only if the respondent said that he or she would keep all policies and 0 (or "no") if the person planned to drop one or more policies or had not decided. Even defined this way, only 17 percent of respondents were assigned a value of zero. Predictor variables included: a variety of demographic, health status and insurance policy characteristics; a measure of concern about out-of-pocket health care costs; measures of satisfaction with Medicare as well as private insurance policies; and a variable indicating whether or not the person was briefed about changes in Medicare benefits.

Results of the logistical analysis revealed that very few factors had a significant effect on the decision to keep supplemental insurance. Perhaps most notably, those who were briefed about the new Medicare benefits were no less likely to say they would keep their policies (a finding consistent with the data shown in Figure 11, page 23). Other findings of interest were that:

- Better-educated individuals were no less likely to say they would keep their policies;
- Those most concerned about out-of-pocket costs were no more likely to say they would keep their policies; and
- Those with higher premiums and those whose premiums increased in the past year were no less likely to say they would keep their policies.

There were only three variables that were statistically significant predictors in the decision to keep a Medicare supplemental policy(ies) (significance level in parentheses). Individuals who claimed to be in fair or poor health were more likely to say they would keep their policies (5 percent). Those who originally obtained their policies through an employer also were more likely to keep them (1 percent). But individuals who said that their policies did not meet all of their expectations said they were less likely to keep them (1 percent).

This last variable had the largest overall effect on the decision to keep or drop private insurance. Table 4 shows that among the 14 percent of respondents who reported that their policies did not meet all of their

Table 4 Policy Owners Who Plan to Keep or Drop Their Policies

	Policy Met All Expectations	Policy Did Not Meet All Expectations
Plan to Keep Policies	86.5%	60.4%
Plan to Drop Policies	1.1	13.2
Don't Know	12.4	26.4

expectations, 40 percent plan to drop a policy or do not know whether they will, versus only 14 percent for those whose policy has met all expectations (significant at the 1 percent level).

Putting these findings together, it appears that the primary reason that some individuals may not retain their private insurance policies is not because of the Medicare Catastrophic Care Act's benefits, but because they are dissatisfied with the private insurance policies. One could easily imagine these people switching to another policy. Thus it appears that even though the catastrophic legislation will change the content of policies, people will continue to purchase them (although one must interpret these results with some caution as it may be too early for most people to have made final decisions about their insurance).

◆ The Appeal of Medicare Supplemental Insurance

There are four major findings that emerge from this survey of Medicare beneficiaries. First, despite the publicity that surrounded the passage of the Medicare Catastrophic Coverage Act, the elderly still know very little about the most basic aspects of the legislation.

Second, in spite of poor understanding, a large majority of the elderly have formed opinions about the legislation and most of them do not like it very much. This is also true of those who were briefed about the legislation's benefits by interviewers.

Third, the elderly are very concerned about all of the gaps that still remain in Medicare, even those that are $600 or less (e.g., the Part A and prescription drug deductibles). They appear to have a strong preference towards complete coverage with no deductibles or coinsurance. In fact, in an open-ended question, most who said they planned to keep their policies referred either to the need for additional protection or that Medicare did not cover all costs.

Finally, the elderly are very satisfied with their private health insurance policies. Few plan to drop them, probably because of their fear of any

remaining costs that are not covered by Medicare. Even those who were briefed about the new Medicare benefits did not want to drop their private insurance policies.

Our overall conclusion is that despite passage of the Medicare Catastrophic Coverage Act, program beneficiaries will still purchase supplemental health insurance policies. Older Americans fear any out-of-pocket expenses that are not covered by Medicare. Insurance companies that provide dependable coverage against these expenses will continue to attract elderly buyers.

Notes

1. U.S. Congress, House, Committee on Energy and Commerce, N. Gordon before the Subcommittee on Health and the Environment, March 26, 1986.

2. T. Rice, "An Economic Assessment of Health Care Coverage for the Elderly," *The Milbank Quarterly* 65, no. 4 (1987):488.

3. T. Rice and J. Gabel, "Protecting the Elderly Against High Health Care Costs," *Health Affairs* 5, no. 3 (Fall 1986):5.

4. U.S. Department of Commerce, Bureau of the Census, *Statistical Abstract of the United States*, 109th Ed., 1989.

5. N. McCall, T. Rice and J. Sangl, "Consumer Knowledge of Medicare and Supplemental Health Insurance Benefits," *Health Services Research* 20, no. 6 (February 1986, Part I):633.

6. See note 1.

7. For a review of the literature, see T. Rice and N. McCall, "The Extent of Ownership and the Characteristics of Medicare Supplemental Policies," *Inquiry* 22 (Summer 1985):188.

8. See note 7.

9. Premium figures do not include policies owned by individuals who worked 30 or more hours a week, since such policies are usually paid for entirely by employers.

10. S. Christensen, S. Long and J. Rodgers, "Acute Health Care Costs for the Aged Medicare Population: Overview and Policy Options" (Washington, D.C., Congressional Budget Office, May 1987).

11. M. Tolchin, "Recipients of Medicare Also Face Rise in Cost of Private Insurance," *The New York Times*, February 12, 1989.

Mr. REGULA. Are there companies getting out of the business of Medigap? I sometimes hear that there are fewer companies offering it because they feel that the risks are too great over the long haul. Or in your experience, are most of the companies that have been offering it continuing to do so?

Ms. JENCKES. I believe that is the case. I have not heard otherwise. But, of course, too, it then depends on what is going to happen with the catastrophic law in the future, and conceivably there will be fewer benefits to offer. I guess on a wonderful note is the fact that some of the companies are looking at long-term care insurance policies. We now have over 100 companies marketing this product and the consumer acceptance so far, with just a very, very burgeoning product, has been terrific and we're very optimistic over the future.

Mr. REGULA. You're offering this in many instances to young people, are you not, so that they can in effect pay a low premium but it nevertheless covers themselves for long-term care in the future?

Ms. JENCKES. Exactly. This is the type policy that started about a year ago and we refer to it as a group available policy. And Proctor & Gamble, for example, in the State of Maryland and the State of Alaska happen to be 3 employers that do offer the coverage, and it's on an employee pay-all basis. The employer is not participating in the cost of the policy. And to the companies' surprise and delight, the average age of sign-up has been the age of 42. So I do think there is a one definite blessing in the catastrophic law and that's that it made the public acutely aware that Medicare does not provide any long-term care or nursing home needs.

So we are very pleased. We have minimum standards that the States are developing and passing to assure consumer protection in this area and we are nothing but optimistic as to what we may be able to deliver to the public.

Mr. REGULA. I know the State of Ohio, the employees of the State, are covered by Aetna, and they offered it to those that are already retired. I was surprised when I saw a premium scale that was relatively inexpensive even for someone in the age of 60 to 65. So apparently they anticipate that it wouldn't be an extensive utilization.

What percent of the individuals covered by Medicare have Medigap insurance? Do you have any idea?

Ms. JENCKES. It's about 71 percent have Medicare supplemental insurance, and again, another 10 percent have Medicaid.

Mr. REGULA. Thank you, Mr. Chairman.

Mr. ROYBAL. Thank you.

The Chair recognizes next Mr. Wise.

Mr. WISE. Mr. Chairman, I appreciate it but I will defer to Mr. Bilbray who has been here ahead of me.

Mr. ROYBAL. All right, the Chair then will recognize Mr. Bilbray.

Mr. BILBRAY. Mr. Chairman, I appreciate your allowing me to appear at this hearing. I'm a member of the full committee but certainly not a member of this, what I consider the most important subcommittee of the Committee on Aging.

My question basically is that I am concerned, as many of the other members are—and I wasn't here at the very beginning and

I'm sure you addressed this—about the area grouping on rate increases.

Seniors, Social Security payments throughout the country, of course, aren't based that they live in Beverly Hills. They are not given a higher social security payment than if they lived in one of the most cheapest economic areas of the country.

Like in my own State of Nevada, according to the percentage of increase in Medigap policies that I have in front of me is 75 percent this year. I know, I pay my mother's Medigap policy and it jumped—and it's closer to the $900 figure that was mentioned a few minutes ago because I've got the bill sitting on my desk right now to pay—quite an incentive to come over here and listen to this testimony.

But my question is this, and this is probably to the non-industry related witnesses: Are we looking down the line of our government getting involved in a Part C, D, whatever it may be, offering a Medigap policy to people of this country on an optional basis within the entire system so that these drastic increases that take place in some States would not take place and it would spread the cost to the policy throughout the entire system? Plus the fact is we won't have to worry about in the future paying all sorts of premiums for people that sell the policies and receive commissions on a daily basis.

I'm sure the industry said, no, the government should stay out of this. But to you that are not industry-related witnesses, do you feel that there's a need for a new Part in Medicare that would be an optional program which would offer the same sort of benefits being offered by private industry to our Medicare recipients that would answer this question?

Whoever wants to take that.

Mr. FIRMAN. I agree with you, there's no question that a publicly provided program, even on an optional basis, would have a number of attractive benefits to senior citizens. It would be a large pool. It would have lower marketing cost, and lower administrative costs. A tremendous amount of the Medigap dollar now is spent on TV advertising and direct mail solicitations. Random digit dialing is another new form of solicitation that our members have been encountering. These automated voices call them up tell them that Medicare is being cut back, and that they need to buy extra supplemental insurance.

Clearly, as I read the history of the original intent of Catastrophic Care Act, expanded hospital benefits were needed to put the hospital indemnity insurance plans out of business. So there's no question that a publicly offered plan to extend benefits could be more efficient and lower cost and clearly better protection for consumers.

I like your suggestion that if we don't want to federalize the whole system, at least we should have a competing public option—I think this is a great idea. I think it would be a very strong option and it would add an element of competition which sometimes seems to be lacking. What we now see, in my view, is an industry-wide attempt to, if not fix prices, certainly condition the market to raise prices. So I think a competing public plan could be a very positive development.

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Mr. Chairman, I apologize that I do have a commitment to testify at a Senate hearing 15 minutes ago, so if there are any other questions I'd like to take them now, otherwise, I'd be very happy to answer any follow-up questions in writing after this hearing.

Mr. ROYBAL. Mr. Firman, what we will do then is ask each member if they have any questions to ask of you, to submit them in writing and we'd appreciate it if you would answer those questions within 2 weeks.

Mr. FIRMAN. I'd be happy to do that. Thank you.

Mr. ROYBAL. Thank you, sir. If you wish to be excused, you may go.

Mr. BILBRAY. Mr. Chairman in conclusion of my statement, just one statement to the committee and to you, Mr. Chairman, I would think that we should pursue the idea of the Part C, D, whatever we want to call it, that is an optional program that would be offered to the members that would be in direct competition with private industry but would, hopefully, like the witnesses stated, drive the price down and also spread the cost throughout the pool. And if this committee could work on that—I'm not a member of this subcommittee but I certainly volunteer my time and my staff's time to work with the members of the staff to try to create such a program.

Mr. ROYBAL. Thank you very much. I think we need a lot of work on this subject. First of all, we have to clarify the vast differences in opinion—is there an actual premium increase that is not justified? That is what we are trying to get at at the present time.

The second important thing that's come to my attention is the fact that the States don't actually review any increase before that increase goes into effect—no one does.

These are things that I think the Congress of the United States has to look at and see if there is some way in which justification would have to be made for the rate increases, if in fact it is shown that there's no justification for them now.

At the present time, Ms. Jenckes, I really don't know. The testimony has indicated that there is no justification on one side, and then on the other side that there is.

We as a committee must look into that question and reach a conclusion. We have already had a survey made that definitely shows that there's no justification. It also shows that increases have been quite tremendous.

In my own State of California, for example, just in 1989, Medigap rates went up 75 percent. In Missouri, 120 percent. Here in the District of Columbia—and I suppose everybody thinks that everyone in the District of Columbia is rich, not so—it went up 55 percent. And in other States that are not the wealthiest States in the Union, it went up an average of 50 to 60 percent.

This committee wants to know why. And so far we haven't had all of the answers. We have some of them.

Mr. REGULA. Mr. Chairman, would you yield?

Mr. ROYBAL. Yes, Mr. Regula?

Mr. REGULA. You mentioned that States don't have any control over rate increases. Ms. Jenckes, how many States require prior approval by an insurance commission or commissioner before there can be rate increases on Medigap?

Ms. JENCKES. It's my understanding that all companies must file their rates with the Department. And some States do, in fact, require approval, some do not. But they can go back in at any time—and I'd like to supply this for the record—over a 3-year period and reject those rates. Again, I would like to clarify that with our State attorneys.

Mr. REGULA. Supply that for the record. I think it's an important element.

[The information follows:]

STATE REGULATION OF MEDICARE SUPPLEMENT PREMIUMS

A quick review of our State regulatory files reveals that with regard to individual coverages, all States require insurers to file their rates before putting them into effect. In 37 of those States, premiums may not be changed without the prior approval of the regulators.

In those States which have a "file and use" regulatory system rather than prior approval, premiums may not be implemented for a period—varying from 30 to 90 days—after they are filed with the regulators. During that period the premium filing may be rejected or further delayed by the State requiring additional information and justification for the proposed change. Even after a premium change has gone into effect, regulators have continuing authority for periods of up to 3 years to have a policy withdrawn from the market or to order the premium reduced if they find that it is not reasonable in view of the benefits provided.

Turning to regulation of group coverages, 16 States have prior approval authority, 20 have a file and use arrangement and 15 do not require prior filing of rates. The rationale for not requiring prior filing of group rates is that the sponsoring group has shopped the market and selected a good value to offer its members. For the same reason, States typically do not require filing of premium charged for large employers' employee health benefits.

Importantly, in all States Medicare supplement insurers are required to file an annual report justifying their experience and loss ratios for the previous year for both individual and group policies. Thus, even where the filing of rates for group policies before they are implemented is not required, insurers must justify their premiums in light of their claims experience and other expenses.

Mr. ROYBAL. Mr. Regula, we also have put in the record a study that was made by the committee, trying to establish the validity of that same situation.

It has been concluded that two-thirds of the States do not give prior approval to group policies.

Mr. REGULA. Does that information—if you will yield further—indicate how many have retroactive approval and would require a reimbursement to the policyholders in the event that they would determine that the rates were unjustified?

Mr. ROYBAL. It does not. I don't believe that there's any way in which they can give back to the policyholder any monies. I've never seen that happen before, and I don't expect that any insurance company is going to do it. However, we don't have that in the survey.

But the survey is very interesting because it does tell us what is happening in all States of the Union, and they're not the same.

Mr. REGULA. That is true.

Mr. ROYBAL. I think that it is important to know that we in the Congress can come in and, with cooperation from the private sector, do something about keeping health care costs down. And in turn, keeping down the cost of insurance.

The Chair will now recognize Mr. Fawell.

STATEMENT OF REPRESENTATIVE HARRIS W. FAWELL

Mr. Fawell. Thank you, Mr. Chairman.

I would like to unanimous consent that a statement I have prepared be received.

Mr. Roybal. Without objection, that will be the order.

[The prepared statement of Mr. Fawell follows:]

STATEMENT OF CONGRESSMAN HARRIS W. FAWELL

BEFORE THE SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

NOVEMBER 2, 1989

MR. CHAIRMAN, I COMMEND YOU FOR HOLDING THIS HEARING ON MEDIGAP INSURANCE AND THE CATASTROPHIC LAW BECAUSE IT PROVIDES AN OPPORTUNITY TO SET THE RECORD STRAIGHT ON THIS ISSUE.

RECENT NEWSPAPER REPORTS HAVE GROSSLY DISTORTED THE IMPACT OF REPEALING CATASTROPHIC ON MEDIGAP RATES. THE REPEAL OF CATASTROPHIC WILL NOT INCREASE THE OVERALL COST OF COVERAGE TO SENIORS OVER 1989 LEVELS.

THE ONLY NEW COST MEDIGAP POLICIES WILL HAVE TO PICK UP OVER 1989 COVERAGE IF CATASTROPHIC IS REPEALED IS THE EXTENDED HOSPITAL STAY PROVISION. BLUE CROSS, THE NATION'S LARGEST MEDIGAP COMPANY, SAYS REPLACING THIS BENEFIT WOULD COST SENIORS AN ADDITIONAL $5.10 PER MONTH IN 1990. AARP SAYS CATASTROPHIC'S COVERAGE OF THIS BENEFIT SAVES SENIORS ONLY $2.25 TO $2.50 PER MONTH IN MEDIGAP PREMIUMS.

REPEALING CATASTROPHIC WILL ELIMINATE A $4.90 MEDICARE PREMIUM INCREASE IN 1990, AND A $7.40 INCREASE IN 1991 THAT ALL SENIORS WOULD PAY. COMPARE JUST THESE SAVINGS TO THE $5.10 BLUE CROSS INCREASE TO REPLACE THE BENEFITS AND ONE CAN SEE THAT REPEAL IS BASICALLY A WASH. THIS IS EVEN WITHOUT TAKING INTO CONSIDERRATION THE HUGE SAVINGS TO SENIORS WHO, WITHOUT CATASTROPHIC, WILL BE NO LONGER LIABLE FOR PAYMENT OF THE "SUPPLEMENTAL PREMIUM" SURTAX.

NEWSPAPER ARTICLES HAVE CLAIMED THAT 1990 PREMIUMS FOR MEDIGAP WILL RISE BETWEEN $8 AND $21 PER MONTH OVER 1989 LEVELS AS A RESULT OF

REPEAL OF CATASTROPHIC. THESE FIGURES ARE INACCURATE BECAUSE THEY INCLUDE A HIGHER PREMIUM TO COVER CATASTROPHIC'S PART B BENEFITS.

BUT, CATASTROPHIC'S PART B BENEFITS ARE NOT IN EFFECT NOW, SO 1989 MEDIGAP RATES DON'T REFLECT ANY PART B SAVINGS. THUS, REPEAL WILL NOT INCREASE PRIVATE INSURANCE COVERAGE FOR PART B OVER 1989 LEVELS, AND PREMIUMS WILL NOT HAVE TO BE INCREASED OVER 1989 LEVELS FOR PART B AS A RESULT OF REPEAL OF CATASTROPHIC.

MEDIGAP RATES WILL CONTINUE TO GO UP FOR A VARIETY OF REASONS: HEALTH CARE COST INFLATION, NUMBER OF CLAIMS, NEW COVERAGE MANDATED BY STATE GOVERNMENTS, AND THE GROWING GAP BETWEEN WHAT MEDICARE CONSIDERS "REASONABLE" CHARGES AND ACTUAL HEALTH CARE CHARGES. BUT THESE INCREASES WHICH WE CAN EXPECT IN 1990 CANNOT BE ATTRIBUTED TO THE REPEAL OF CATASTROPHIC. IN JANUARY 1989, AARP RAISED ITS MEDIGAP RATES 40 PERCENT WITH CATASTROPHIC IN FULL EFFECT.

THE REPEAL OF CATASTROPHIC WILL RAISE 1990 MEDIGAP RATES OVER 1989 TO COVER PART A BENEFITS ONLY, AND THESE MEDIGAP INCREASES WILL BE OFFSET BY DECREASES IN THE MEDICARE PREMIUM.

MR. CHAIRMAN, WE OWE IT TO SENIORS TO GIVE THEM ACCURATE INFORMATION ABOUT WHAT THEY CAN EXPECT IF CATASTROPHIC IS REPEALED. AGAIN, THANK YOU FOR HOLDING THIS IMPORTANT HEARING THIS MORNING AND GIVING ME THE OPPORTUNITY TO MAKE THESE REMARKS.

Mr. FAWELL. Mr. Chairman, you are to be commended for calling a hearing such as this because I think there is no topic in all this land that is more in the minds of people, certainly our senior citizens, and that is the rising cost of the delivery of health care services. But all Americans, everyone, is trying to figure out how in the world do we get a handle on this.

Mr. Chairman, with the possible repeal of catastrophic care, a number of newspapers have speculated, and I think in some cases it's been just speculation, as to the cost increase of Medigap coverage for 1990 be compared to the 1989 cost of the Medigap private insurance. There's been a lot of misunderstanding.

My office and I have spent a lot of time with Blue Cross and Blue Shield and other insurers. This morning Blue Cross has indicated that if there is total repeal, then insofar as any new obligations being cast upon private insurers for the 1990 calendar year, it would be only the Part A expanded coverage, which is now covered by catastrophic.

I asked Blue Cross and Blue Shield if they could tell me what would be the increased cost as a result of having to accept this new coverage of Part A back again. Blue Cross said $5.10 per month would be the increase in cost.

I notice that AARP has indicated previously that with the advent of the Part A expanded Medicare coverage being accepted for the year 1989 that it cause a reduction in their premium cost of only about $2.25, $2.50.

I express these figures, Mr. Chairman, because I want to make it clear that I think there has been gross exaggeration in those news stories that have indicated that repeal would cause tremendous increase in cost by private insurers who assume Part A coverage.

I think that this is very important to establish because there's so much misunderstanding and seniors can be understandably quite frightened if they believe that a repeal of catastrophic would singularly be the cause of great increases in the cost of 1990 Medigap rates.

Not only that, but most news media has not mentioned that if the expansion of Part A is transferred to private insurance in 1990 that there will be a corresponding elimination of the $4.90 special flat rate premium under catastrophic. That flat premium cost will jump to $7.40 the next year 1991. So it's just about a wash.

Now, I'm not implying that there still will not be increases in Medigap coverage in 1990 (unrelated to repeal of catastrophic), as there is in everybody's coverage. And I wish, Mr. Chairman, I had some solution that I could offer for those increases that are taking place in everyone's health care insurance.

Mr. BILBRAY. Will the gentleman yield on that point?

Mr. FAWELL. Yes.

Mr. BILBRAY. I think the statement of the Health Insurance Association of America, page 8, spells out what the industry stand is, that if MCCA is totally repealed it will be a 20-25 percent increase.

Mr. FAWELL. First of all, percentages confuse me and they confuse most of us, I think—one would have to look at what that means in dollars and cents. We must remember too, that Part B is now covered by Medigap insurers because Part B has never been picked up by the catastrophic care bill. So I've tried to stress that if

we're talking about what the increase will be in 1990 because of the repeal in terms of comparing with 1989, there's only one additional new cost that is going to be put upon Medigap insurers, and that is only the added Part A cost. And Blue Cross and all the insurers I've talked to have said that's about a $5 or $6 per month cost.

By the way, HHS agrees with Blue Cross and Blue Shield in regard to these costs, I think, they said roughly of insuring for the expanded Part A benefits, it's about a $5 per month or $60 a year in the actuarial cost in giving this flat premium a charge to everybody in Medicare.

So both government and private insurers both apparently agree that actuarily that's what we're talking about. I hope that can help because I've had so many people calling me and they've read some of these sensational stories that I think have been just out of line.

The other point, Mr. Chairman, is, let's assume that the McCain amendment were to prevail and the expanded Part A remains in effect. I have suggested that under the McCain proposal you basically do have the Federal Government now in the insurance business, no welfare aspect to it, the full cost of providing that insurance is to be paid by the Medicare recipients across the board equally. No one portion of that group is subsidizing another group. It's across the board.

I'm sorry that Mr. Firman left because he said, government ought to be able to do a better job cost-wise than private industry because they have a large pool that they can draw from. On the other hand, they have to take high risks that private insurers don't have to.

But I've suggested to Senator McCain, why not have this Part A benefit be optional; admit that the Federal Government, for the first time, is in the business of selling insurance policies. They apparently believe they can do a better job than private insurance. Some think that maybe they can. I've got severe questions whether government can outcompete and be more efficient than private enterprise, but let's assume that that's a possibility, certainly. Then why not think in terms of an optional Part A expanded benefits rather than the McCain amendment which would make it automatic, that is all Medicare recipients must take it, even though it duplicates coverage, and so forth and so on.

I would like to see that as a possibility. All Medicare recipients would be in but they could opt out within a year, let us say. Then we would begin to see how many people would opt out. They wouldn't opt out if it's a better premium or more efficiently operated insurance program. It might be a very interesting experiment, Mr. Chairman.

I don't know if any one of the people who have testified might have a comment, or Ms. Jenckes, you might have a comment.

Mr. Roybal. The time of the gentleman has expired. However, if there's any brief response, we'll accept it.

Ms. Jenckes. We'd be happy to look at that and respond for the record.

I would just be concerned if people started dropping out of Part A, what effect that would have really on the Medicare program in terms of adverse selection.

Because the government has no sales costs, does not charge its full administrative costs, does not pay premium taxes, and is insuring the entire eligible population—thus spreading the risk across the widest possible group—it can provide the Part A catastrophic benefit for a lower premium than would be charged by a private insurer.

However, if participation in that benefit were optional, the beneficiaries with the least need for it would tend to opt out while those with the greatest need would remain. This "adverse selection" phenomenon would drive the premium upward, making it less affordable for many low income elderly persons.

An optional Part A catastrophic benefit would also complicate the administration of both Medicare and private insurance supplementing Medicare. There would be some Medicare beneficiaries with catastrophic protection and some without, complicating Medicare claims processing for the government. Private insurers would need to offer an additional type of policy in order to match the needs of persons who had the Part A catastrophic benefit but wanted private insurance to supplement Part B of Medicare. Finally, the states would all have to revise their Medicare supplement laws and regulations to allow the new product to be sold.

Mr. Roybal. The Chair recognizes Ms. Oakar.

Ms. Oakar. Thank you, Mr. Chairman.

I just wanted to call my friend's attention to the chairman's table in his report to the full committee where he lists the increases in the price of Medigap policies during the period when Medicare increases were about 10 percent, which is also in the chairman's original statement, and the average increase was more than 25 percent. In States, my own State of Ohio, was 33 percent increase. Arizona was 133 percent increase. The District of Columbia—I don't think there's tremendous wealth in the District, and certainly all segments of the District's elderly population—and they went up 55 percent.

So I mean this is really an interesting and important documentation.

I wanted to ask all the panelists or any in particular, I want to make sure the industry answers this question if I could, but I really would like the response of all.

Two-thirds of the States don't review rate increases. They don't even file reports relative to increases, although the States review utility prices, et cetera, and most States have an Office of Insurance.

I just wondered how all of you would feel if there were some mandating that the States be required to review these wholesale increases.

We were told in an earlier hearing that was held by this committee during the catastrophic plan, that if the catastrophic plan passed and was in action that there would be a reduction of these Medigap prices; and in fact, there was an increase, and a dramatic increase. Now there's the threat of more increases.

So I wondered how you would feel about the States being mandated to review the increases and to file that? Did you want to answer, Ms. Gloss?

Ms. GLOSS. Massachusetts does review the increases. In fact, rate hearings on MEDEX—on Blue Cross/Blue Shield—are ongoing. Since early fall we've been fighting the rate increase of 33⅓ percent.

Ms. OAKAR. And you can appear and testify like you would in a utility hearing?

Ms. GLOSS. Yes, we did. In fact, I testified twice. Once was on the drug deductible and the other was on the rate hearings. It hasn't really been settled. The problem with Massachusetts is that there is no money to really hire expert witnesses to go over the figures because the insurance companies can crunch the figures and do whatever—you know, make the figures look the way they want them to.

Ms. OAKAR. But I'm told by our distinguished staff director here that Massachusetts is not required to review group policies. But they are required to review individual policies.

Ms. GLOSS. That's right. The MEDEX they must review.

Ms. OAKAR. Right.

The thing is, most States do not review and do not file. I am just wondering whether you think there ought to be like the highway bill, some sort of omnibus requirement nationally that States be required to review increases so that consumers have access to knowing what these prices are going to be and can file their—openly talk about the problems and do some review in terms of the advocacy that sometimes go on.

Do you think that would be helpful?

Ms. GLOSS. Last year, Blue Cross/Blue Shield came in with a request of 18 percent and the advocates and the seniors were able to limit it to 10 percent. So we were successful.

Ms. OAKAR. It works when you have a certain process.

Ms. GLOSS. It does.

Ms. OAKAR. Did you want to respond, Mr. Gilmore?

Mr. GILMORE. Yes, I would.

I'd like to see that the States, one, be mandated—that they must review, whether it's a group policy or individual policy.

In the State of Florida, individual policies must be filed and reviewed by the insurance commissioner. One particular company that I know of filed for a rate increase of about 12 percent in the middle of 1989. The State of Florida allowed them a 4 percent increase because of their review and procedure.

I think when you find that the insurance industry is not mandated by law to file for a review of premium increases that it's left up to the marketplace, whatever the market will bear. This is a product that senior citizens purchase out of fear to begin with—they know that Medicare doesn't cover all the bills. And I think that if seniors are going to be purchasing products out of a certain fear of their future, then I think it's the government's responsibility to protect them any way that they can against unscrupulous types of tactics and also against price gouging on the part of any type of industry that is basically designed to protect them for a profit.

So I would recommend mandated reviews of all insurance premiums in every State in the United States.

Ms. OAKAR. How about you, Ms. Jenckes?

Ms. JENCKES. We are required to file all of our rates, is my understanding. But I indicated earlier, Congresswoman, that I will check on that for the record.

Ms. OAKAR. With the States?

Ms. JENCKES. —insurance departments. While we are required to file, some States automatically would review the rates. But it's my understanding that within a 3-year period of time—and I believe it's 3 years and that's why I'd like to clarify this for the record, the State can go in at any time and reject that rate or question or challenge that rate.

Ms. OAKAR. Are you saying that there is some national law that says over a 3-year period the State can review—

Ms. JENCKES. That's not a national law, it would be—

Ms. OAKAR. What is it?

Ms. JENCKES. State law. That is what I would like to supply for the record so that I'm absolutely correct. But it is my understanding that any State can go back—it's an individual State law, which gives the insurance department the authority to go back and challenge it.

Ms. OAKAR. They have the authority but the point is that two-thirds of the States do not require any kind of filing or rate increase requests in terms of having an open forum about it the way they do for utilities. I think that is one of the problems.

How would you feel, though, if we did some legislation that mandated that?

Ms. JENCKES. I'm not sure if it has to be mandated. What we would like to do is work with you and the NAIC (National Association of Insurance Commissioners,) and individual State insurance commissioners to see the feasibility of that.

I would tell you, when the rate increases are really high, insurance companies would feel it immediately because consumers would not buy the product.

Ms. OAKAR. See, here's the problem. I wish that were true, that they had options. The problem is, that you have a situation where the average older American consumer has Medicare which covers 45 percent of their needs and they need this other portion covered, and most Medigap policies, if you will pardon me, don't do a terrific job in covering.

I know my people back home, and I'm very fond of them personally and so, they'd say, at least Blue Cross is doing something, nobody else would take this—you know, that kind of thing. I don't think they would do it unless it was somewhat profitable.

But nonetheless, the point is that you almost hold them hostage because where else do older people go? They don't have another option because we do such a terrible job in this country of covering them comprehensively, let alone all the other people who have no coverage.

I wanted to ask you, so I mean, the fact is that consumer argument normally would be a pretty good one but their choice is pretty much take or leave it, and they have some critical needs out there in terms of health delivery.

Ms. JENCKES. I have to just make one comment, Congresswoman, in terms of that.

When Medicare first passed in 1965, there was not even the idea that a Medicare supplemental policy would exist. Since many of these people obviously worked before attaining the age of 65 and did have comprehensive employer-provided insurance—they are the ones that in fact came to the commercial insurance industry as well as Blue Cross and Blue Shield, when they realized the inadequacy of the Medicare program. They in fact came to us and asked what we could do to supplement because Medicare was not providing all of the benefits that the consumers felt were necessary and wanted.

Ms. Oakar. That's probably partially true, that you're filling a certain need there. But do you think that you would be in the business if it weren't a pretty profitable industry?

Ms. Jenckes. I don't think we'd be in the business if people didn't want to buy the benefits that we offer. We have worked together with consumer groups, the Department of Health and Human Services, and the NAIC to determine exactly what those benefits should be.

In 1980, the minimum standards were in fact put into law that many of the consumer groups agreed with. Some of those benefits have been expanded to additionally meet consumer needs. If the consumers in fact feel that they would like more in the way of coverage, we'd be happy to respond to that and work with them.

I also feel that if the costs were prohibitively high they wouldn't purchase it.

I think we have put a tremendous product together on the marketplace.

Ms. Oakar. Do you work with the consumers about price? Do you work with the consumer groups about what they should pay?

Ms. Jenckes. I'm sorry?

Ms. Oakar. Do you work with the consumer groups about what they should pay? Is there any reconciliation?

How is it that the District of Columbia rates can go up 55 percent in 1 year? I mean, come on, really.

Ms. Jenckes. Health care costs are different in various parts of the country, and I think we, together, have got to do something to address the cost equation for everybody under or over age 65.

Ms. Oakar. But you don't say that it was inordinate? You wouldn't acknowledge that, would you?

Ms. Jenckes. I don't know the factors that were involved in the increase.

Ms. Oakar. Let me ask you one other question, Mr. Chairman, if I may, and then I will conclude here, and that is: Do you have a penalty for people switching policy, or is there any kind of open season kind of advocacy that you would, on behalf of the industry, make?

One of the things we're finding in the Pepper Commission, and it exists for all age groups, is the tremendous discrimination against people in this country. We had somebody testify—a woman with a chronic ailment. She was making $70,000 a year. The chronic ailment has not surfaced, and she cannot purchase an insurance policy—absolutely cannot get one—let alone, the poor person or the moderate income person, or the elderly person who has a need to

have gaps covered that aren't covered under Medicare, the government program.

One of the things that we're seeing—and I want to say it publicly because I think it's really something that was called to my attention—is the tremendous amount of discrimination on behalf of the insurance industry—how outrageous, that they can pick and choose who they want, and expel people who have been long-time policyholders because they develop an illness.

I thought insurance was supposed to insure you for things you hoped never happened. You hope you never get a chronic problem, but if you do you can get insurance in this country from the private sector.

What is the industry doing about the blatant discrimination going on not only for older people but others?

Ms. JENCKES. I've got two points to make on that. One, we do have a comprehensive proposal on the uninsured, which in fact will address that question.

And for some of the truly high-risk individuals, we recommend State pools for the medically uninsurable, and 20 States have them today. I think that is one option that we can look at.

We're also looking at uninsurable groups and our recommendation is that we have a reinsurance mechanism that the private sector in essence would handle to take care of high-risk groups.

There are many other facets to it, and what I'd like to do is share that with you and Mr. Chairman and the committee if they would so like, and in particular as it relates to—

Ms. OAKAR. I'd be happy to see that because that's a new one.

[HIAA Uninsured Proposal follows:]

10/31/89

HIAA UNINSURED PROPOSAL

The HIAA believes that proposals for covering the uninsured should build upon the existing system and should call for both public and private sector expansion. We have developed such an approach.

The Poor - Persons below the federal poverty line

One cannot expect the private sector to make significant inroads in covering the poor population. Today, Medicaid fails to cover over one-half of the poor population.

- The Medicaid program should be expanded to cover persons who fall below the federal poverty line. Also, for poor persons who are working and have employer coverage available, states should be given the option of paying employee premium contributions and copayments to enroll them in such plans. We call this "buy-out."

The Medically Needy - Persons above the poverty level with large, catastrophic expenses

- All states should enact Medically Needy programs with eligibility established at the federal poverty line. This would permit persons not otherwise eligible for Medicaid due to higher income to become eligible for full Medicaid coverage by spending the difference between their income and the federal poverty line on health care expenditures.

The Near Poor - Persons between 100% and 150% of poverty

- For the Near Poor (those between 100 and 150% of poverty), a Medicaid "Buy-In" program should be developed. Under the "buy-In" persons would be allowed to pay a small income related premium for first dollar coverage of primary/preventive care only (no inpatient hospital or outpatient surgical care). This income related premium would range from next to nothing for those just above poverty to $50-60 for a family of three at 150% of poverty.

- Persons making a transition into the work force and into the ranks of the near poor (those whose income pushes them above the poverty level but below 150% of the poverty level) should receive a year of transitional coverage. Here too, states should be given the option of extending Medicaid coverage or paying employee premium contributions and copayments to enroll such individuals in employer plans when they are available. This is the transitional "buy-out" population.

Make Private Coverage More Affordable

Small employers have particular difficulty in affording health insurance coverage.

- Private insurers should be allowed to sell lower cost plans which are free from state provider and benefit mandates.[4] To accomplish this, ERISA preemption of state mandates for self-insured plans should be extended to insured plans. This would allow insurers to sell more affordable coverage to small employers while eliminating the inequity between employers able to self-insure (large employers) and those unable to do so (small employers).

- A 100% federal tax deduction for the purchase of health insurance should be extended to the self-employed (as is now the case for corporations).

Ensure that Coverage is Available to All

- For high cost employer groups, a private not-for-profit reinsurance mechanism should be established to ensure that coverage is available. Employers would access the reinsurer indirectly via insurers or directly if unable to purchase coverage from an insurer. Losses from the reinsurer would be financed entirely by the private sector if shared equitably across the marketplace.

- For uninsurable individuals, all states should enact qualified high risk pools. Pool losses would be financed by state general revenues or other broad based financing mechanism which does not assign losses disproportionately to any individual or corporate entity.

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[4] There are currently close to 700 state provider and benefit mandates nationwide. Gail Jensen at the University of Illinois has estimated that 16% of the smallest employers choose not to offer coverage because of state mandates.

Ms. JENCKES. We've got it and we're very pleased. It's been 2 years in the making and has used the best and brightest talent from the industry. We really feel our proposal will come a long way in addressing some of the concerns you raise.

In terms of the Medicare supplemental population, I'd like to say that since a good portion of these policies are individual policies, and most of them are what we refer to as guaranteed renewable policies, which cannot be cancelled unless just for lack of payment.

While we have no data on this point, we estimate that, including Blue Cross and Blue Shield policyholders as well as those served by commercial insurers, at least three quarters of the policies currently in force may not be terminated by the insurer except for fraud or non-payment of premium.

In addition, it should be noted that NAIC standards for 1990 will require all Medicare supplements offered for sale to be guaranteed renewable.

I think this is one way that individuals can be served by continual policy on the part of the industry.

Mr. ROYBAL. The time of the gentlewoman has expired.

The Chair recognizes Mr. Wise.

Mr. WISE. Thank you, Mr. Chairman.

I'd like to follow up on that. You say that they cannot be cancelled but that's not to say that anyone who walks in the door can sign up for such a policy; is that correct?

Ms. JENCKES. Each individual company has their own underwriting rules.

Mr. WISE. So if someone comes in, age 65, 67, with pre-existing illness or something like that, they could be denied coverage; is that correct?

Ms. JENCKES. They can be denied coverage policies regardless of the company that's offering them, whether it's us, Blue Cross/Blue Shield, and we may in fact impose a pre-existing condition limitation. I believe the maximum for that is 6 months. It goes back to the old adage, nobody would ever buy insurance until they had to use it, and that's something that applies throughout the law, if you will, or universe of insurance.

But once in the system, and whether it be a 2-month limitation or the 6 months maximum amount of time, in accordance with the Medicare supplemental insurance minimum standards, then full coverage is made available.

Mr. WISE. I think that illustrates the difference between private industry and the Medicare plan. Medicare takes everybody and Medicare doesn't have the option of dropping anyone, which I think becomes an important factor.

I want to follow up, Ms. Jenckes: I understand that almost every State and every insurance company will file their rates.

Ms. JENCKES. Correct.

Mr. WISE. That's not to say they are subject to review; or more importantly, they're not subject to approval or disapproval.

I also understand that the insurance industry, and I believe HIA is part of this, has greatly resisted, for a lot of reasons, Federal regulation. But would the insurance industry, and particularly the health insurance industry, be willing to go on record as sup-

porting every State reviewing and approving applications for rate increases in Medigap insurance?

Ms. JENCKES. I would have to look at that. I think that's something that we could definitely consider. I don't want to make an absolute commitment on it. I'd like to work with individual insurance commissioners to see the feasibility of that.

Then again, I'd like to also clarify for the record exactly what each State imposes and what have you, I had not yet seen the chairman's survey on this, so I'd like to do that.

Mr. WISE. But which is the present position of your organization; to oppose increased regulation and approval by States or to support such regulation?

Ms. JENCKES. I don't believe we have a position on that. Again, we're working with the National Association of Insurance Commissioners to do whatever we can to assure that beneficiaries have the best product and best price product on the marketplace. This may be in fact one of the options they're considering, and I'd be happy to get back with you on that.

Mr. WISE. I appreciate that.

I think we're all getting tossed into an incredible box and we're all going to have to work out way out of it.

Mr. Chairman, I appreciate this hearing because I think you've opened the lid on what is now an untold story, but is going to be the great firestorm of 1990 and 1991.

The 1989 firestorm was catastrophic illness. I presume—I can read votes—that it's probably to be repealed; not by my vote, incidentally, but it will probably be repealed.

But what has not been noticed is the extent to which people have canceled their Medigap policies or existing health coverage because they felt that catastrophic would be in effect. What has also not been noticed are the figures that the HIA itself—the Health Insurance Association of America—has put out that estimate premium increases alone to go up 20 to 25 percent allowing repeal.

So the idea of repeal saving senior citizens great out-of-pocket expenses for premiums is refuted totally by even the industry's figures which show that we should look for a rate increase. The rates are going up with catastrophic 7 to 12 percent, by the industry's records. But with repeal, it's going up 20 to 25 percent. And I've got a feeling that if it is based upon the same projections that were made a couple of years ago showing there would be no rate increase with catastrophic, that it's going to go up far, far more than that.

So whatever happens, repeal or no repeal, I think seniors are in a real heck of a shape right now and Medigap insurance is going to be called upon to deal with this, and I don't think Medigap can. So this Congress is going to have to go back to dealing with this issue in more significant ways.

Mr. Chairman, as I say, I think this is an incredibly timely topic and I hope it also points out the need for States, in the absence of Federal regulation, to be looking at those rate increases, and not to go on just letting them be filed—that's easy.

We do a comparative survey in West Virginia every year on what the rate increases are. It's not just a case of being able to tell people what the rate increase was last year and what it's going to

be this year. It's a case of actually reviewing it and trying to hold those costs down.

Thank you, Mr. Chairman.

Mr. Roybal. Thank you, Mr. Wise.

Mr. Regula?

Mr. Regula. Thank you, Mr. Chairman.

Just two questions, Ms. Jenckes.

What percent of your Medigap policies are individual versus group? Because I note in the committee's study that 32 States do require a review of individual policies, a lesser number of group policies. So I'd be interested what the percentage is of each.

Ms. Jenckes. I believe, and I'd like to clarify this for the record, I think 25 percent are sold on an individual basis and about 40 percent on group basis.

Mr. Regula. So that's 65. Now, how about the other?

Ms. Jenckes. And the others could be sold through the mail.

Mr. Regula. So they'd be in effect individual policies?

Ms. Jenckes. In effect, yes.

Mr. Regula. So essentially the majority of policies are individual policies and subject to review by the States; is that a fair statement?

Ms. Jenckes. I think that's a fair statement. But again, I'd like to get you the exact figures.The HIAA 1989 survey of Medicare beneficiaries revealed that 46 percent had coverage (mostly group coverage) obtained through their own or a spouse's employer or former employer. Of those with coverage not obtained through an employment relationship, 45 percent had obtained it through membership in a group of association, 44.5 percent purchased it directly from a company or agent, 7 percent bought it by direct mail response, and 3.5 percent belonged to an HMO.

Mr. Regula. The other thing is, I noticed in your statement you said there's a growing use of outpatient treatment. It would seem as if you're using outpatient as opposed to hospital treatment would reduce costs of medical care overall, and yet, we have this rising cost. I just wonder if you're explain that dichotomy.

Ms. Jenckes. I think it's just the sheer volume of services and then again, no restrictions or no; changes in the way physicians are being paid where there are in fact parameters to hospitals—

Mr. Regula. You're saying because it's outpatient in the physician's office this is being charged under Part B or under physician's costs as opposed to hospital care, which is subject to the DRG restrictions; is that a fair statement?

Ms. Jenckes. Correct. And we're finding that more and more services are being done. So again, the volume is going up, the cost of technology, even the cost of physician reimbursement is going up.

Mr. Regula. Then you're saying because of outpatient treatment—it's more readily available—there's a greater utilization?

Ms. Jenckes. Exactly.

Mr. Regula. Thank you.

Thank you, Mr. Chairman.

Mr. Roybal. Thank you, Mr. Regula.

Ms. Jenckes, I would like to establish, if we possibly can, what the true cost increase has been. You mentioned that increases in

prevailing charges paid to doctors was the cause, or part of the cause, for increased premiums.

Now, in our committee findings, we see that there have been increases—a 3 percent rise in the doctor's fees and 4 percent in hospital fees.

Are those percentages correct?

Ms. JENCKES. Yes, Mr. Chairman. Last year, Medicare did approve a 3 percent increase in the amounts that were paid to participating primary care physicians.

Mr. ROYBAL. Would you then agree that the increase is in the neighborhood of, let's say, between 7 and 10 percent? That that is the increase that is recognized by Medicare?

[No response.]

Mr. ROYBAL. All right, if that is the case then, how can a 25 percent increase be justified?

Ms. JENCKES. Mr. Chairman, let me go back and try to explain what this means, and these are very, very unofficial estimates from the Association. Again, the GAO will be looking at the individual company rates. And I think what became confusing here is that we are looking at Medicare and catastrophic as it exists today; what could happen if Part B continued to go into effect—

Mr. ROYBAL. But the increases I made reference to are for this year.

Ms. JENCKES. And that is 7 percent—

Mr. ROYBAL. Why has there been that increase in costs? I'd like to know what the cost has been this year and what the increase has been this year.

My understanding is that the cost increase is in the neighborhood of 7 percent, but the premiums have been increased in the neighborhood of 20 to 25 percent.

Is that a correct assumption?

Ms. JENCKES. I think on the part of some companies they may in fact have gone up 20, 25 percent. It is our estimate that on an average they probably went up 8 to 10 percent.

I think you could get that information from individual companies.

Mr. ROYBAL. But surely, if we base our conclusions on the survey that has been made, I don't think there's a single State that has reported that the increase has been less than 10 percent. Some of them were as high as 133 percent. Why this wide discrepancy?

Ms. JENCKES. I think, Mr. Chairman, again, the cost of care is different in different parts of the country. I think some policies may have a mix of Medicare beneficiaries who utilize the services more. There are a whole number of factors that could cause the—

Mr. ROYBAL. Let's agree to the fact that the cost of care is different in different parts of the country. But the social security recipient that lives in D.C. and that one that lives in California gets the same or approximately the same benefit.

Now, a case in point is the testimony that Ms. Gloss has given with regard to Mrs. Weiner. Mrs. Weiner had a monthly bill of approximately $267 that she paid just for medicine. She is very much concerned that her insurance will be going up, since she has a fixed income. Then we find in that particular situation, if the rates do go up, these people have to make some though choices. I heard

you say that the Weiners haven't dropped their insurance, but that they had to go without something else. So, many seniors, like Mrs. Weiner and others, will have to cut down on their eating, perhaps.

Mrs. Weiner's husband is 80 years old. He requires certain medication. We know she's not going to cut back on that medication. If she does, she endangers that man's life immediately, and she's not going to do that. So she's going to cut back on something else. That could very well mean malnutrition. The consequences are tremendous.

So we can establish then that there's been an increase in cost, that the increases may be different in every State. But that the income of the senior citizen is practically the same. If that is the case, what can be done to keep costs down?

One of the things that was brought to my attention was the fact that the agent's share of the premium that is received for the first year is up to 75 percent. It seems to me that that is excessive.

Does your organization recommend the continuation of that policy?

Ms. JENCKES. Are you referring to the agents?

Mr. ROYBAL. The agents, yes.

Ms. JENCKES. The agents' commissions?

We are looking at the whole area of agents' commissions again, as is the National Association of Insurance Commissioners. But I'd just like to explain the very vital role that agents can play in again. They market to, let's say, a lesser percent of the population because in fact so many people have it as part of their either retirement plans or receive it through a group such as the American Association of Retired Persons.

But an agent in many cases plays a very, very useful role in assisting the Medicare beneficiary—explaining the benefit changes, helping them to file their claims, which is sometimes a very confusing process that people attest to. So the services of the agent for the commission rates that first year are really amortized over time while they really serve as a very, very valuable tool to the Medicare beneficiary in understanding the program.

Mr. ROYBAL. Mr. Gilmore, can you answer that same question?

Mr. GILMORE. Yes. The comment that I'd like to make it is that if 70 to 75 percent of an insurance premium, first-year insurance premium, remains in effect you're going to have the same type of abuses that we see in the insurance industry right now.

As I stated before, Medicare supplemental insurance is sold to the individual very often by using fear and scare tactics. People buy this out of fear because they know that Medicare doesn't do the complete job.

However, if you want to have honest, reputable insurance representatives, agents, in the field who are going to service their clients and who are going to do a good job in making sure they receive benefits properly from Medicare and from the insurance, I would recommend to lower the first-year commission rate to fairly close to the level of a renewal commission. Most insurance agents receive about 10 to 15 percent for second-year renewals.

However, if you keep a high first-year rate, many insurance agents will sell a policy to an individual and receive a high commission for it and then the next year sell them a different policy to

retain the first-year level commission. If you brought that first-year level commission down, more and more agents would rely on their second year commissions and, therefore, do a better job of servicing the policies and servicing the clients who really need the servicing and the education and everything that goes along with it.

Mr. ROYBAL. Thank you, Mr. Gilmore.

I would like to find out a little bit more about the State of Massachusetts.

Ms. Gloss, is there any estimate of the number of seniors in your State who can no longer afford private insurance and have dropped it? What is the situation?

Ms. GLOSS. I don't have the figures. We do have the figure of 175,000 seniors that cannot afford it at all. They really have to rely on emergency rooms and they don't go to the hospital to get the care they need at all.

Mr. ROYBAL. Ms. Gloss, 175,000 in that State that don't have insurance at all?

Ms. GLOSS. They don't have Medigap insurance.

Mr. ROYBAL. Now, there's an additional number that do have insurance and are having a hard time paying the premiums?

Ms. GLOSS. Absolutely.

We heard the figure in Massachusetts during the Blue Cross hearings that 40 percent of the premium goes for administrative costs and it's only 60 percent that goes to services that are required. So that's quite a large amount of money.

Mr. ROYBAL. Let us take your own situation. You already mentioned it and I think that we can mention it again. You have an HMO bill of approximately $2400 a year?

Ms. GLOSS. Right.

Mr. ROYBAL. That to me seems quite high, but maybe not—let's find out.

What do you get for it? What kind of coverage do you get for that investment?

Ms. GLOSS. I'm very pleased with the coverage. I'm lucky that I can afford it. I pay $5 for every visit to a doctor—and I have an excellent doctor—and $5 for each prescription.

Mr. ROYBAL. It costs you then a premium plus $5 every time?

Ms. GLOSS. Right, plus $5, and $5 for every prescription. My husband takes high blood pressure medication that he has to take every day of his life. That would be quite expensive if we didn't have that HMO.

Mr. ROYBAL. So the more you go then for service, the more $5 you have to put out?

Ms. GLOSS. Absolutely.

Mr. ROYBAL. And you have stated that your income is so limited—

Ms. GLOSS. We do have some savings, thank goodness.

Mr. ROYBAL. You have some savings?

Ms. GLOSS. We're not that bad off yet.

Mr. ROYBAL. You're one of the lucky ones that are not bad off.

Ms. GLOSS. I feel very lucky.

Mr. ROYBAL. But it's still costing you $2400 a year plus your visits?

Ms. GLOSS. Plus the visits, right.

Mr. Roybal. I'm not going to ask Mrs. Weiner, but do you think Mrs. Weiner could afford to pay what you're paying?

Ms. Gloss. Her out-of-pocket costs are probably $255 for herself every month. I have the whole list of medications that just her husband takes.

Mr. Roybal. Her income is $700 a month?

Ms. Gloss. What?

Mr. Roybal. Mrs. Weiner's income is $700 a month?

Ms. Gloss. Oh, no, my mother's is.

Mr. Roybal. Let's take your mother then.

$700 a month?

Ms. Gloss. Yes.

Mr. Roybal. Now, supposing your mother had an income of $700 a month, and had the same kind of expenditures—do you think she could afford it?

Ms. Gloss. Absolutely not.

Mr. Roybal. What I'm trying to get at is that there are some of us who are senior citizens who are lucky to have a little more income than the average. But we're not the average.

Ms. Gloss. We're not.

Mr. Roybal. The average senior citizen I think is the one that we are making reference to, and I think that your mother is the average senior citizen. Not you and me, Ms. Gloss.

Ms. Gloss. No, the average older person over 80 years old hasn't paid in that great amount that the people now have paid in. So they get a minimum amount of social security. My mother's social security check is about $400 but she also has some interest or something like that.

Mr. Roybal. All right, now your $2400 a year, does that cover nursing home care?

Ms. Gloss. Oh, of course not.

Mr. Roybal. It does not?

Ms. Gloss. No.

Mr. Roybal. So it covers your privilege to visit a clinic or a doctor once a week?

Ms. Gloss. If I want to. I hope I don't have to. It doesn't cover long-term care at all. Right now we are taking a chance and not buying the long-term care policy. Right now I think the minimum in Massachusetts is $1,000 for a long-term care policy. And they are really not comprehensive and we're not very happy with the ones that are being written.

Mr. Roybal. Again, what I'm trying to show is that there is a difference between you, Ms. Gloss, and your mother.

Ms. Gloss. Absolutely.

Mr. Roybal. And that the difference is vast.

Ms. Gloss. It is very. Most people we speak to are in my mother's category.

Mr. Roybal. All right, most people, you say, will be in your mother's category, and these are most elderly people throughout the entire country.

Ms. Gloss. A lot of them are single women—

Mrs. Weiner. Over 70.

Ms. Gloss. —that haven't worked, that have not earned a lot and have very, very limited incomes. They are single because their hus-

bands have died and they had to spend down every dime that they had in the first place, leaving them penniless.

Mr. ROYBAL. I know that in my district, for an example, there are not very many who are as lucky as we are.

Ms. GLOSS. That's right, most of them aren't.

Mr. ROYBAL. Most of them are in your mother's category, and it is very difficult for them to get by. They don't really have a nice living, but they have to exist on the $700 to $1,000 they receive a month.

Ms. GLOSS. It's impossible, really.

Mr. ROYBAL. And then when you become of age, the little illnesses here and there, you require more medication, more visits to the doctor— it's rough.

Ms. GLOSS. They have to choose between medication and food, and they usually have to choose the medication—and then malnutrition causes more problems.

Mr. ROYBAL. When they pick between medication and food, other problems come into effect, other complications.

Ms. GLOSS. That's right.

Mr. ROYBAL. So they can't win, can they?

Ms. GLOSS. They can't, absolutely.

Mr. ROYBAL. Mrs. Bentley, do you have any questions either along this line or anything you'd like to raise?

Mrs. BENTLEY. Thank you, Mr. Chairman.

Mr. Chairman, I do want to commend you for holding this hearing today on a subject of vast importance to our seniors.

I have a statement and ask unanimous consent to have it included, Mr. Chairman, on the opening.

I'd like to ask you, Ms. Gloss, when you were presented with the possibility of getting the HMO coverage or Medigap coverage, did you receive enough information about what was included in your proposed policy or your proposed purchase?

Ms. GLOSS. We did on the HMO. My brother-in-law had an HMO through his company.

Mrs. BENTLEY. I see.

Ms. GLOSS. And got very, very sick for 6 years and was covered completely. That was one of the things that made it attractive, with his hospital stay. There were no papers and no copayments involved. And when I found a very good doctor that was good for our family—we're very pleased with that kind of coverage. Perhaps it doesn't work for everybody, but it does for us.

Mrs. BENTLEY. Mr. Gilmore, I was interested in your comment that one of the problems with some of the agents was that by reselling another policy the agents would pick up another commission after the first year. You suggest that the second year should be the high year—at least the second year should be the high year for the commission or is that what you were saying?

Mr. GILMORE. The commission should be leveled off a little bit more. Your average agent himself is going to receive about 50 percent of the first year premium and he's going to receive about 10 percent of the second year.

Mrs. BENTLEY. I see.

Mr. GILMORE. What I think should happen is that the first—

Mrs. BENTLEY. Fifty percent in the first year?

Mr. GILMORE. Fifty percent in the first year.

Mrs. BENTLEY. And 10 percent in the second year?

Mr. GILMORE. Ten to 12 in the second year.

Mrs. BENTLEY. Of the premium?

Mr. GILMORE. Of the premium.

What I think should happen is that first-year commission should drop down to 30—30 percent—and pass the savings along to the insured. If one does that, if the insurance industry does that for its sales agents, it would eliminate a lot of what is called "book rolling" where an agent will take all his clients from what he sold last year and in order to keep a high commission go out and say, "that company's not doing all that well," and, boom, sell them all different new policies to keep that high 60 percent commission.

It also gives him the impetus to take care of the people that he has already and service their policies and service them through the Medicare system also and take care of their paper work because the main bulk of his income is going to become from the people he sold 3 years ago, 4 years ago, and 5 years ago, not the people he's selling right then and there that day.

Mrs. BENTLEY. So if you reduced the agent's fee, the commission, down to 30 percent the first year, then what would it be the second year?

Mr. GILMORE. Fifteen percent.

Mrs. BENTLEY. Fifteen?

Mr. GILMORE. Sure.

Mrs. BENTLEY. And then 15 from then on?

Mr. GILMORE. Yes, for the life of the policy.

Mrs. BENTLEY. And you think that would be enough to prevent him from trying to re-roll into another policy?

Mr. GILMORE. It will prevent him from trying to re-roll other agents' work. In other words, going into someone's home, somebody who has a good Medicare supplement, and kind of twisting them out of that supplement.

It will also put hindrances on him from doing it to his own clients in order to keep up a high commission level. Fifty percent on a $700 premium is a lot of money.

Mrs. BENTLEY. Who determines the premium levels and the amount of the fee of the agent?

Mr. GILMORE. The home office of the insurance companies.

Mrs. BENTLEY. The home office?

Mr. GILMORE. Yes, ma'am.

Mrs. BENTLEY. And are they all pretty much the same?

Mr. GILMORE. They're all fairly much the same.

I'm a master or a marketing general agent for a few companies and a general agent for all my other companies. The commission doesn't stop with the agent itself. It moves up the line. It goes from agent to general agent to managing general agent to marketing director.

The agent himself receives the bulk of the commission but there's a good deal of commission from the sales agent on up.

The home office of the company usually decides what the commission is going to be. In some States, however, there are loss factors that have to be considered because there are some States that

do regulate how much a company can make in a profit on an insurance policy, Medigap policy.

My experience has been that there aren't all that many States who do have that strict a regulation. Florida is one State that does have a strict regulation. But still, it is left up to the home office of the company to decide how much it's going to pay its marketing team.

Mrs. BENTLEY. I see.

What is your estimate of the impact of the total repeal of the catastrophic law or partial repeal such as the Regula-McCain plan upon premiums? What effect will this have upon premiums?

Mr. GILMORE. None of the companies that I deal with have indicated to me to lobby my Congressmen or anything of that nature to have the catastrophic health care act remain intact. None of my companies have told me that they expect massive premium increases—none of my companies.

Now, keep in mind that I represent the 25 percent of the market that buy individual policies and not group policies. But one of the things that I think that will happen is that—and I see it starting to happen now—once the people in Florida realize that catastrophic is going to be chopped up and not go in its entirety, is that many agents are trying to convince their prospective clients that they have to buy more insurance now because the benefits of catastrophic are not going to be there—they want them to buy up.

There are two ways they're having them do that. One way I may agree with, the second way I do not. First, a lot of agents are telling people to cover their liability for those charges that Medicare does not approve, that go above and beyond what Medicare approves—above and beyond the participating rate on Part B.

Second: The thing that I do not agree with is now there is another flood of nursing home insurance policies in the State of Florida. And as this committee has shown in the past, that many of the long-term care policies out on the market, the vast majority of them are not good buys for the general public—at least the individual policies are not, they're not good buys.

So this is an element where if catastrophic is up in the air, people are becoming frightened. And, unfortunately, it is in some respects, unfortunately, it's my industry who is left up to educate the general public about what is going on, and it's an industry that relies on the individual market, individual salespeople, and they're making a 50 percent commission whenever they sell something.

Mrs. BENTLEY. Who could bet regulate this, a Federal law on the commissions, or should it remain in the hands of the States?

Mr. GILMORE. I think that a combination of both would be good. I think that because we're dealing with a system—we're dealing with a system that is quasi-sponsored by the Federal Government, the Medicare system.

Medigap policies are linked to the Medicare system, just even on a marketing standpoint they're linked to the Medicare system—they're there to fill the gaps that are left over by Medicare.

I believe if you look at it that way then the Federal Government has a right to make decisions on how they're sold, what kind of commissions can be generated, and what kind of premiums should go for those policies. They are there to supplement a government

subsidized program to begin with; so, sure, the private sector should be there but I think government intervention and government regulation is perfectly justified.

Mrs. BENTLEY. Thank you, Mr. Chairman.

Mr. ROYBAL. Thank you, Mrs. Bentley.

We would like to conclude the hearing but before we do that we're going to ask each member of the panel if they have a closing statement for one minute or would like to ask questions for one minute. We will follow that by asking the witnesses if they have a 1-minute closing statement. You don't have to make one but if you have one, you're welcome. Then I will close the hearing.

The Chair now recognizes Ms. Oakar.

Ms. OAKAR. Thank you, Mr. Chairman.

I am going to make a statement and maybe they can answer it in writing.

I want to get back to your point affordability, and you were saying there are all these seniors in your district who are not as—you're not particularly well off, but as well off as you. The average woman's social security check is $400 a month; two-thirds of the elderly are women; the average is about 5 or 550 if you factor in the male factor in terms of who are recipients of social security. Twenty percent of the women have another kind of small pension but 80 percent have nothing else. That's pretty much what most women and men live on their social security checks.

And if you take a look at the figures you gave us, the $88 you pay plus for Medigap, which covers the same kinds of things that Medicare covers, and the $28 for Medicare—that's about $116, $120, plus all the other little doctor fees and so on.

When I first came here in 1977, we used to say that 1 out of 4 dollars of older Americans was spent on health care. The fact is it's probably now 1 out of 3.

So if you have $250 left a month, and that's your only source of income, how are you supposed to live on that? And that really is where it is.

I think the insurance industry is really somewhat inordinate when you consider that your $17 billion industry, for this area only, and 60 percent are benefits, risks, commission, and other fees—you know, come on now. There's some mutual kind of collaboration that should be undergoing in this country and it's not happening.

Thank you, Mr. Chairman.

Mr. Wise?

Mr. WISE. Thank you, Mr. Chairman.

I just want to underscore a point that I've been thinking about even more sitting here, and that is if you think that the senior citizens of this country were upset this year over catastrophic illness and what they pay, wait until next year when the Medigap increases go into effect to make up the difference for the repeal of catastrophic. They're going to be tearing the marble off the walls around here. This is a question that has to be addressed by the Congress.

What concerns me is that the States aren't prepared to address it and that's the only place for regulation. Yet, we find that most of the States are simply filing the rates but not really reviewing or

rejecting them and sending them back. We've got a real crisis on our hands.

Thank you, Mr. Chairman.

Mr. Roybal. Thank you.

We'll start with Ms. Jenckes—do you have a final statement?

Ms. Jenckes. Yes, Mr. Chairman. I would just like to say that we're extremely proud of our record in covering people whether they're under the age of 65 or over the age of 65. We feel that what our agents have done, we feel what the State regulation of insurance done, and together what you have done, to, let's say, make sense out of the Medicare catastrophic program to date has been tremendous.

We think the hearing today will open up the dialogue even more.

I just want to emphasize, when it comes to the rates, which was indeed the focus of the hearing today, those are largely due to rising health care costs, which again, are a problem for everyone, regardless of age. I think we all have to roll up our sleeves and do something to solve that problem, and then I hope the cost of our policies may come down and we will be able to continue to offer the public what it wants in the most effective manner that we can.

Thank you.

Mr. Roybal. Thank you.

Mr. Gilmore?

Mr. Gilmore. Mr. Chairman, I think that this whole situation comes down to just a few basic things. First, I think that our insurance industry in the United States, our health insurance industry, must be responsible, not only to the general public and to States, but also to the Federal Government.

Second, I believe that people in the insurance industry at my level, agents must be responsible to the people who they serve. Serve the public for a profit and the profit will naturally come.

Third, it's my hope that through all this, through the Catastrophic Health Care Coverage Act and the big brouhaha that is happening now, that the general public will become educated consumers about what is going on in Medicare and in private coverage.

Thank you.

Mr. Roybal. Thank you.

Ms. Gloss, do you have closing statement?

Ms. Gloss. I believe that the catastrophic illness bill was not really explained very well to the average older person. They were hysterical right away when they heard that they were going to pay—each one said, oh, my goodness, I'm going to have to pay $800 for me and $800 for my husband, a surcharge on my income tax, every single year.

And I said, gee, do you really think you earn that much money?

They thought that everyone would have to pay the maximum, and they were frightened that it was going to be just too much money and they didn't understand. We had seniors that called their representatives—they don't even pay income tax, they earn such a low amount, but they were frightened. It was not explained carefully enough that it would not affect them, and that it would only affect a certain amount of people and not everybody.

Mr. Roybal. Thank you, Ms. Gloss.

I'd like to thank each and every one of the witnesses.

And if I may have my last minute, I would like to point out that the hearing has been very helpful, that the problem has been very clearly articulated, that Ms. Gloss has pointed out there is a problem and has used her own mother as an example of the problem that does exist throughout the country.

Also pointed out that Mrs. Weiner has a specific problem that makes it most difficult for her to, number 1, drop any insurance that she may have because if she does drop it, she may be able to eat a little bit more but in order to keep her insurance she's going to have to cut down on something else. That is the problem.

Then I think that we also went into the responsibility factor, where it's all agreed—I think everyone agreed—that the insurance companies must be more responsive. I don't think there's any disagreement there.

But then we also concluded that rates in various States have or will be increased by as much as 133 percent. Then there's been somewhat of a justification to that, saying that the costs have increased throughout the country and that each State may have a different cost factor than the others.

What is clear and convincing is the fact that 33 percent of the States approve rates at the present time, which means that all the rest of the States do not. Again, what is clear and convincing, is that this committee must consider, and we will, and craft legislation that will require that rate increases be reviewed and approved before going into effect.

When we prepare that legislation—and it's going to be soon—I would like to submit that to you, Ms. Jenckes and have you comment on that, and then see what we can do about the situation as it exists today.

I think that these tremendous increases throughout the country are not justified. I think that some of the things that are going on with regard to the industry itself could be greatly improved, to say the least.

However, this is something that we cannot do immediately, but we must head in the right direction. And I think that this hearing is the first step in that right direction.

I would like to thank you, Ms. Jenckes, Mr. Gilmore, Ms. Gloss, and Mrs. Weiner for being here today and making this hearing very interesting. You have told us the facts and agreed to cooperate with this committee as we try to develop means and ways of remedying the situation.

We thank you very much.

Ms. Jenckes. Thank you, Mr. Chairman.

Mr. Roybal The meeting is adjourned.

[Whereupon, at 12:20 p.m., the hearing was adjourned.]

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